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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 15 1945

Registration District No. 835

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3732

Primary Registration District No. 6128-4492

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Oran
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott 100

(c) City or town Oran. 4
(If outside city or town limits, write "RURAL") 0

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ✓ 0

3. (a) PRINT FULL NAME William Eli Lloyd

3. (b) If veteran, ✓
name war

3. (c) Social Security No. ✓

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive years

7. Birth date of deceased April (Month) 11, (Day) 1864 (Year)

8. AGE: Years 79 Months 9 Days 17 If less than one day hr. min.

9. Birthplace — (City, town, or county) Ind. 1 (State or foreign country)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name William Lloyd 1
13. Birthplace — (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Mary Oliver
15. Birthplace — (City, town, or county) Indiana 1 (State or foreign country)

16. (a) Informant Louisa Lloyd
(b) Address Oran, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Friend, Oran. Mo.

18. (a) Signature of funeral director Bisplinghoff & Hubbard
(b) Address Chaffee Mo.

19. (a) 1/31/45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 28
year 1945 hour 1 minute 20 A.M.

21. I hereby certify that I attended the deceased from DEC 18, 1944, to JAN 27, 1945
that I last saw him alive on JAN 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchio-pneumonia	6 da
Due to Influenza	14 da
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature [illegible] (M. D. or other) DO
Address Oran Mo Date signed 1/30/45

102 (Licensed Embalmer's Statement on Reverse Side)

Dr. Skillings

RECEIVED
District Health Office No. 2
District File Number 245-167
Date Filed 2-7-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Mamie Bispling hoff

Licensed Embalmer No. 3242

P. O. Address Chaffee, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.