

FILED FEB 16 1945

Registration District No. 133

Primary Registration District No. 3022

Registrar's No. 161

1. PLACE OF DEATH:  
(a) County Harrison  
(b) City or town Bethany  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Wood Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community all of life  
years, months or days)

3. (a) PRINT FULL NAME Lois Nadine Tilley  
3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Nov 5 1934  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>10</u>	<u>2</u>	<u>3</u>	hr. _____ min.

9. Birthplace: Bethany Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation: at home

11. Industry or business: \_\_\_\_\_

12. Name: Bert Tilley

13. Birthplace: Bethany Mo  
(City, town, or county) (State or foreign country)

14. Maiden name: Armed Bender

15. Birthplace: New Hampton Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant: Bert Tilley

(b) Address: Bethany Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 10 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation: Miniam Cemetery

18. (a) Signature of funeral director: Joe E. Wheeler

(b) Address: Bethany Mo

19. (a) Jan-18-1945 (Date received local registrar) (b) Zola M. Burris (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Harrison  
(c) City or town Bethany  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8  
year 1945 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 4, 1945 to Jan 8, 1945  
that I last saw him alive on Jan 8, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Thrombosis  
Due to: Appendix Operation

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 12/17  
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) (c) Means of injury \_\_\_\_\_

23. Signature: Ralph H. Walker (M. D. or other) J. D.  
Address: Bethany, Mo Date signed: 1/18/45

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

**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

*Joe E. Wheeler*

Licensed Embalmer No. *3512*

P. O. Address. *Bethany Mo.*

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

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