

No. 2
-5-43
5-17-39
1 X38671

FILED MAR 12 1945
Registration District No. **270**

Primary Registration District No. **3052**

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

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Sedalia
(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) 1

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community LIFE
years, months or days

3. (a) PRINT FULL NAME LILLIS HUSTON

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 3

5. Color or race Negro

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

6. (b) Name of husband or wife Chris Huston

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased July 4 1902
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>42</u>	<u>7</u>	<u>16</u>	hr. _____ min. _____

9. Birthplace Pettis Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Harrison Frye

13. Birthplace Pettis Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Sabell Cameron

15. Birthplace Pettis Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Marjell Brown

(b) Address Sedalia Mo

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 2-21-45
(Month) (Day) (Year)

(c) Place: burial or cremation Georgetown Mo

18. (a) Signature of funeral director F. W. Ferguson

(b) Address Sedalia Mo

19. (a) 2-21-45
(Date received local registrar)

(b) Ma Anna Berger
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pettis 80

(c) City or town Sedalia
(If outside city or town limits, write "RURAL")

(d) Street No. 508 W. Pettis
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17
year 1945 hour 11 minute 10 M.

21. I hereby certify that I attended the deceased from Feb 9
1945 to Feb 17 1945
that I last saw her alive on Feb 17 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Stenosis Duration _____

Due to Confection & Nephritis ✓

Due to _____

Other conditions (include pregnancy within 3 months) _____

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 A. W. Calaway (M. D. or other) _____
Address Sedalia Mo Date signed 2/20-45

1822

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-8-42

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

F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Bedelia

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. 27x

Primary Registration District No. 2052

Registrar's No. 55

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Lillie Huston

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced (49)

6. (b) Name of husband or wife Mrs. - 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 42 Months 7 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day _____ year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Chronic Congestive & nephritic CARDIAC. Edemat.

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 D W Dawson (M. D. or other)

Address Sedalia Mo Date signed 2-20-45

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10851