

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23314
Registrar's No. 170

FILED AUG 10 1945

Registration District No. _____ Primary Registration District No. 3000

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

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

3. (a) PRINT FULL NAME Hila Lee Cathell
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm. D. Cathell 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Oct. 1 1893
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day
51 | 9 | 18 | _____ hr. _____ min.

9. Birthplace Scotland Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER { 12. Name James N. Lancaster
13. Birthplace Scotland Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Josephine Right
15. Birthplace Scotland Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. D. Cathell
(b) Address Kirksville, Mo

17. (a) Burial (b) Date thereof 7/22/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hills Cemt.

18. (a) Signature of funeral director D. P. Kelly
(b) Address Kirksville, Mo.

19. (a) 7-27-45 (b) Mrs. J. H. Wagner
(Date received local registrar) (Registrar's signature)

1099

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 605 W. Scott
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
year 1945 hour 12:00 minute _____ P; M.

21. I hereby certify that I attended the deceased from Jan. 1945 to July 19 1945
that I last saw her alive on July 19 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage uterus
Due to Carcinoma of Cervix

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 RO Stickler (M. D. or other) GMD
Address Kirksville mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8-45-1204

SEP 25 1945

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..... *D.E. Reilly*

Licensed Embalmer No. *4141*

P. O. Address *Westville W.D.*

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.