No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30841

State File No.

Registration District No. 166 Primary Registration District No. 5605 Registrar's No. 20

1. PLACE OF DEATH:

(a) County Johnson

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

(c) Name of hospital or institution: Station Hospital, Sedalia AAFld Warrensburg, Missouri
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County Unknown 999

(c) City or town Detroit 20
(If outside city or town limits, write "RURAL")

(d) Street No. 1314 Magnolia St 0
(If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No) 2

If yes, name country -

3. (a) PRINT FULL NAME PFC WILLIAM LALLY 16 065 283

3. (b) If veteran, name war World War II

3. (c) Social Security No. -

4. Sex Male 0

5. Color or race white

6. (a) Single, widowed, married, divorced - 9

6. (b) Name of husband or wife -

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

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

8. AGE: Years Unknown | Months - | Days - | If less than one day - hr. - min.

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

10. Usual occupation Soldier

11. Industry or business U. S. Army

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Army Record
(b) Address Camp Carson, Colo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/29/45 (Month) (Day) (Year)
(c) Place: burial or cremation Detroit, Mich.

18. (a) Signature of funeral director Geo Dillard
(b) Address Sedalia, Missouri

19. (a) Sept. 28/45 (Date received local registrar) (b) Erma L. Beatty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 25 year 1945 hour 0715 minute A M.

21. I hereby certify that I attended the deceased from 25 September, 1945, to 25 September, 1945; that I last saw him alive on 25 September, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death 1-Hemorrhage, cerebral

Due to fracture, depressed, right frontal and parietal bones, compound, comminuted. Fracture, right & frontal sinus and right ethmoid and cribriform plate. Wound, severe, contused, right posterior thorax, upper.

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1700 8 21

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 25 September 1945

(c) Where did injury occur? Higginsville, Mo (City or town) (County) 34 (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 2½ miles west Higginsville, Mo, Highways 40&13 (Specify type of place)

While at work? No (e) Means of injury Struck by a "hit-&-run" auto driver.

23. Signature Momo Hill (M.D. or other) MC

Address Station Hospital, Sedalia Date signed 28 Sept 45

1400 (Licensed Embalmer's Statement) AAFld, Warrensburg, Mo

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 L. E. Boulelin

Licensed Embalmer No. 3867

P. O. Address Sedalia 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.

No. 2B
—3-45
P I X43880

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. oep

Registration District No. 166 Primary Registration District No. 5605 Registrar's No. 20

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Johnson Washington

(b) City or town Kronaster Rural
(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)

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

3. (a) PRINT FULL NAME William Lally

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

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

8. AGE: Years — Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Erma L. Beatty (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 20
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

30841