

FILED DEC 31 1945

Registration District No. _____

Primary Registration District No. **3010**

Registrar's No. **364**

1. PLACE OF DEATH:

(a) County **Loafe Girardeau**
(b) City or town **Loafe Girardeau**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 weeks**
(Specify whether **Life**)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Loafe Girardeau**
(c) City or town **Loafe Girardeau**
(If outside city or town limits, write "RURAL")
(d) Street No. **828 North St**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LILA S. MOORE**

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 **MARRIED**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased **NOV. 16 - 1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **11** Days **21** If less than one day _____ hr. _____ min.

9. Birthplace **Powhatan Ark. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Liciera Stuart**

13. Birthplace **don't know 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Williams**

15. Birthplace **Loafe Girardeau Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **H. S. Moore**

(b) Address **Loafe Girardeau**

17. (a) **Burial** (b) Date thereof **Nov. 7-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lorimer Coem.**

18. (a) Signature of funeral director **Walthus Und. Co**

(b) Address **Loafe Girardeau Mo.**

19. (a) **11-10-45** (b) **G. B. Zimmerman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV** day **7th**
year **1945** hour **9** minute **07 A.M.**

21. I hereby certify that I attended the deceased from **August 25** 19**45** to **NOV 07** 19**45**
that I last saw her alive on **NOV 16** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the caecum with metastasis**

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **4608**

Major findings: Of operations **Carcinoma of caecum also, bowel obstruction**
Of autopsy **no 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 **R. A. Ritter, M.D.** (M. D. or other)

Address **Cape Girardeau, Mo.** Date signed **11-8-45**

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

16
1
4

EMBED

Public Health Officer No. 4

District File Number 1245-137

Date Filed 12-6-45

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 Virgil W. Kelik

Licensed Embalmer No. 4102

P. O. Address Cape Breton

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.