

8. No. 2  
-3-43  
5-17-39  
1 X37823

**FILED JUL 15 1946**

Registration District No. \_\_\_\_\_ Primary Registration District No. **3002**

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

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution: Audrain Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain

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

(d) Street No. 626 E. LOVE  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie Dobyns

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 23, 1857  
(Month) (Day) (Year)

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

89 7 3 14 hr. min.

9. Birthplace Mason County, Ky.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

12. Name Silas Dobyns

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

14. Maiden name Lacy Gooch

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

16. (a) Informant Ralph Dobyns

(b) Address Mexico, Mo.

17. (a) Burial (b) Date thereof 6/10/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director [Signature]

(b) Address Mexico, Mo.

19. (a) 6/10/46 (b) Blanche Neely  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7  
year 1946 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 6, 1946 to June 7, 1946; that I last saw her alive on June 7, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic degenerative myocarditis Duration 1 yr

Due to Severely dilated aortic valve

Due to Senility

Other conditions Fractured left femur 4-6-46  
(Include pregnancy within 3 months of death)

Major findings: The aorta 4/28

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) None

(b) Date of occurrence Partial femur but level of death

(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? Home  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Harry J. O'Brien (M. D. or other) D

Address Mexico, Mo. Date signed 6-10-46

RECEIVED

District Health Officer No. 10

District File Number 7-46-1368

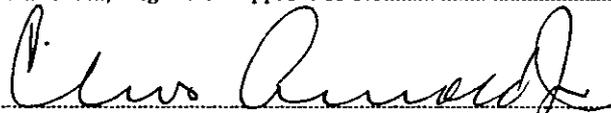
Date Filed JUL-12-1946

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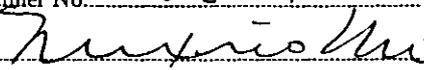
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 3569

P. O. Address 

**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.**