

**FILED** SEP 10 1946  
 Registration District No. 201

Primary Registration District No. 57344314

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

**1. PLACE OF DEATH:**  
 (a) County Macon  
 (b) City or town Atlanta  
 (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 no (Specify whether)  
 In this community all her life years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County macon  
 (c) City or town Atlanta (Rural)  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Lillie F. Gross  
**3. (b) If veteran,** name war no  
**3. (c) Social Security** No. no

**4. Sex** Female **5. Color or race** white  
**6. (a) Single, widowed, married, divorced** widowed  
**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if**  
 alive dead years  
**7. Birth date of deceased:** Feb 11 1864  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>6</u>	<u>17</u>	hr. _____ min. _____

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

**10. Usual occupation** Retired

**11. Industry or business** Lived on farm

**12. Name** Mr. Raymond

**13. Birthplace** East Knoxville  
 (City, town, or county) (State or foreign country)

**14. Maiden name** Ruth Henderson

**15. Birthplace** East Knoxville  
 (City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. Maude Johnson  
**(b) Address** Atlanta Mo

**17. (a)** Burial **(b) Date thereof** Aug 29 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Still Cemetery

**18. (a) Signature of funeral director** Wm. G. Giddings  
**(b) Address** Atlanta Mo  
**19. (a)** Aug 31 46 **(b)** Mrs. O. B. Muffie  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 28  
 year 1946 hour 9 minute 2 - M.  
**21. I hereby certify that I attended the deceased from** January 1 - 1946  
 \_\_\_\_\_, 1946 to Aug 28, 1946  
 that I last saw her alive on August 20, 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Valvular Disease of Heart  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death): \_\_\_\_\_

Major findings: 950  
 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)  
 (c) Means of injury \_\_\_\_\_  
**23. Signature** G. B. Hyde (M. D. or other) \_\_\_\_\_  
**Address** Atlanta Mo **Date signed** 8-29-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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RECEIVED  
District Health Officer No. 10  
District File Number 9-46-1637  
Date Filed SEP-7-1946

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.....

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.**