

FILED MAY 19 1947

Registration District No. **38** Primary Registration District No. **3006**

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

1. PLACE OF DEATH:
 (a) County **Boone**
 (b) City or town **Columbia**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Ninety six days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Ray**
 (c) City or town **Camden**
(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 **Walker, Lillian M.**
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **5**
 year **1947** hour **4** minute **40** A.M.
21. I hereby certify that I attended the deceased from
1-29, 1947, to **5-5**, 1947;
 that I last saw her alive on _____, 19____;
 and that death occurred on the date and hour stated above.

4. Sex **F** / race **W**
 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **M**
 6. (b) Name of husband or wife **Robert I. Walker**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **June 30 1901**
(Month) (Day) (Year)

Immediate cause of death **Pneumococci**
 Duration _____
 Due to **Carcinoma of the breast with generalized metastases**
 Due to _____

8. AGE:	Years	Months	Days	If less than one day
	45	11	5	_____ hr. _____ min.

Other conditions (include pregnancy within 3 months of death) _____
 Major findings: _____
 Of operations _____

9. Birthplace **Troy Kansas**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

Of autopsy **Generalized metastases from carcinoma of breast**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 11. Industry or business _____
 12. Name **Shelby Davies**
 13. Birthplace **Kansas**
(City, town, or county) (State or foreign country)
 14. Maiden name **Maggie (Unk) Davies**
 15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

16. (a) Informant **Robert I. Walker**
 (b) Address **Camden, Missouri**
 17. (a) **Burial**
(Burial, cremation, or removal) (b) Date thereof **May 6 1947**
(Month) (Day) (Year)

(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)

(c) Place: burial or cremation **Camden Mo**
 18. (a) Signature of funeral director **Eschmann**
 (b) Address **Richmond Mo.**
 19. (a) **5-5-47** (b) **Mrs R E Palmer**
(Date received local registrar) (Registrar's signature)

While at work? _____
 (c) Means of injury _____
 23. Signature **de egats** (M. D. or other)
 Address **State Cancer Hospital** Date signed **5-5-47**

Date Filed 5-15-47

District File Number _____

District Health Officer No. 8,

RECEIVED

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 *[Signature]*

Licensed Embalmer No. 2073

P. O. Address Richardson, Tex.

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.