

No. 2  
1-2-43  
5-17-39

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 25 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32120

Registrar's No. 52

Registration District No. 288

Primary Registration District No. 5969

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

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Blunnegan  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1

(If not in hospital or institution, write street number or location)

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

In this community Life  
years, months or days)

3. (a) PRINT FULL NAME Everett Lee Lilly

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased Sept. 11 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 2 hr. min.

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

10. Usual occupation Infant

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

MOTHER FATHER  
12. Name Odas Lilly Kane  
13. Birthplace Earlevale Kane  
(City, town, or county) (State or foreign country)  
14. Maiden name of Graham  
15. Birthplace Shenandoah Iowa  
(City, town, or county) (State or foreign country)

16. (a) Informant Odas Lilly  
(b) Address Blunnegan, Mo.

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director T. H. Pimm

(b) Address Chumanville, Mo.

19. (a) Sept. 18, 1947 (b) Ralph Gorden  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 84  
(c) City or town Blunnegan 0  
(If outside city or town limits, write "RURAL.")

(d) Street No. \_\_\_\_\_ (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13  
year 1947 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 11, 1947, to Sept 13, 1947.  
that I last saw him alive on Sept 13, 1947.  
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital debility Duration \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 2

23. Signature D. E. D. Brown (M.D. or other) DO  
Address Colbert, Mo. Date signed 9/15/47

Licensed Embalmer's Statement on Reverse Side

Date filed 9-24-49  
District 8  
Division 2  
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.....

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.**