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FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED MAY 24 1948

Registration District No. 185

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16894

Primary Registration District No. 5692

Registrar's No. 14

58
00
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Fountain Grove Rural
(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 44 years
years, months or days

3: (a) PRINT FULL NAME Ida Bell Lisby

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 Widowed
6. (b) Name of husband or wife William Newton Lisby
6. (c) Age of husband or wife if alive D years
7. Birth date of deceased October 3 1869
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 11
If less than one day _____ hr. _____ min.

9. Birthplace Clarksburg, West Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Josephus Billingsley

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

14. Maiden name Mary W. Sullivan

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

16. (a) Informant Mrs. Minnie Derickson

(b) Address Meadville, Missouri

17. (a) Burial (b) Date thereof 5-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stepp Cemetery

18. (a) Signature of funeral director Norman Funeral Home

(b) Address Chillicothe, Missouri

19. (a) May 15-1948 (b) Chris A. Maiting
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn
(c) City or town Fountain Grove
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14th
year 1948 hour 11 minute 34 P. M.

21. I hereby certify that I attended the deceased from May 1-14
1948 to May 11 1948
that I last saw her alive on May 11 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia, Bronchial
Bilateral
Due to Cardiac Decompensation
Duration 5 days

Due to Hypertension
Duration 10 yrs

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 107
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature Joseph Conrad (M. D. or other) M.D.
Address Chillicothe, Mo Date signed May 15-48

1907 18 MAR 1909

DISTRICT HEALTH OFFICE
Chillicothe, Mo.

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 Elton F. Norman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

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.