

FILED JUL 15 1948

State File No.

Registration District No. 978

Primary Registration District No. 1003

Registrar's No. 6046

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Barnes Hospital, 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
 (Specify whether years, months or days)
 In this community.....

2. USUAL RESIDENCE OF DECEASED:
 (a) State Illinois (b) County Masaac 999
 (c) City or town Brookport 11
 (If outside city or town limits, write "RURAL")
 (d) Street No. NR (If rural, give location) 2
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME ANNA H LILLIE
 3. (b) If veteran, name war No
 3. (c) Social Security No. None
 4. Sex Female 5. Color or race White
 6. (b) Name of husband or wife Frank Lillie
 6. (c) Age of husband or wife if alive 2 years
 7. Birth date of deceased May 11 1878
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 6th
 year 1948 hour 5pm minute 21 M.
 21. I hereby certify that I attended the deceased from 6-29 1948
 1948 to 7-6 1948
 that I last saw h. er alive on July 6 1948
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 1 25 hr. min.
 9. Birthplace Hamletsburg Illinois 1
 (City, town, or county) (State or foreign country)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name William Mosley 7
 13. Birthplace Unknown 7
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown 9
 (City, town, or county) (State or foreign country)

Immediate cause of death
Acute cholecystitis, perforated
gall bladder, and subdiaphragmatic
abscess.
 Due to Non-calculous Cholecystitis
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy As above
 Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Elsie Oidtman
 (b) Address 4507 Parkview
 17. (a) Removal (b) Date thereof 7-7-48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Brookport, Ill.
 18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.
 19. (a) JUL 7 1948 (b) J. F. Bradley
 (Date received local registrar) (Registrar's signature)

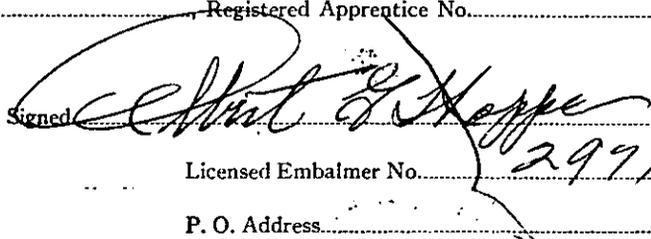
22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?.....
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work?..... (Specify type of place)
 (e) Means of injury.....
 23. Signature F. B. Bradley (M. D. U)
 Address Barnes Hospital, Date signed 7/7/48

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed 

..... Licensed Embalmer No. 299

..... 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.