

Registration District No. 128 Primary Registration District No. 5465

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

1. PLACE OF DEATH:  
 (a) County Greene  
 (b) City or town Rural, N. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
1370 N. Brown St. 1.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 8 yrs  
(Specify whether years, months or days)

3. (a) PRINT-FULL NAME THOMAS TILMAN LILE  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. ?

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced, Married  
 6. (b) Name of husband or wife Laura Lile  
 6. (c) Age of husband or wife if alive 69 years  
 7: Birth date of deceased February 15, 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>6</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Farmer

MOTHER, FATHER {  
 12. Name John Lile  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name Fannie Blades  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant A.A. Lile  
 (b) Address 908 Marion, Springfield Mo.

17. (a) Burial (b) Date thereof 19-09-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Woods Chapel Cemetery

18. (c) Signature of funeral director R. J. Hunsicker, Chgo. Mo.

(b) Address Republic Mo.  
 19. (a) 9-4-1948 (b) W.S. Handley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Greene  
 (c) City or town Springfield - Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1370 N. Brown  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2nd  
 year 1948 hour 1:30 minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from 1944  
 \_\_\_\_\_, 19 \_\_\_\_\_, to Sept 2, 1948  
 that I last saw him alive on Sept 1 (11 AM)  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute coronary  
fatal arteriosclerosis  
 Due to Coronary Thrombosis  
 Due to Arteriosclerosis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 94A

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. F. Bull (M. D. or other) MD  
 Address Springfield, Mo. Date signed 9-3-48

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*R. E. Pearson*

Licensed Embalmer No.

*503*

P. O. Address

*Republic Mo*

**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.**