

THE DIVISION OF HEALTH OF MISSOURI
 FILED MAY 7 1949 STANDARD CERTIFICATE OF DEATH

State File No. 14553

BIRTH NO.		REG. DIST. NO. 320		PRIMARY REG. DIST. NO. 6112C		Registrar's No. 10	
1. PLACE OF DEATH a. COUNTY SCOTT				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SCOTT			
b. CITY OR TOWN RURAL KELSOTWP		c. LENGTH OF STAY (in this place) 3740.		c. CITY OR TOWN RURAL KELSOTWP			
d. FULL NAME OF HOSPITAL OR INSTITUTION. AT HOME 1/2 MILE EAST OF ILLMO				d. STREET ADDRESS (If rural, give location) 1/2 MILE EAST OF ILLMO			
3. NAME OF DECEASED (Type or Print) LILLIE CORNELIUS BARNES		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH APRIL 27 1949		(Month)		(Day)		(Year)	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JAN 25, 1873	
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) COMMERCE, MISSOURI	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME MATHEW ROSE		13b. MOTHER'S MAIDEN NAME ARMENTIA FOX		14. NAME OF HUSBAND OR WIFE LEE BARNES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME John Barnes		ADDRESS St Louis Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Labor Pneumonia INTERVAL BETWEEN ONSET AND DEATH 3 Days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 490X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Apr 24, 1949, to Apr 27, 1949, that I last saw the deceased alive on Apr 27, 1949, and that death occurred at 12:20 P.M., from the causes and on the date stated above.							
23a. SIGNATURE H. F. D. ... (Degree or title) M.D.				23b. ADDRESS Illmo, Mo		23c. DATE SIGNED 4-29-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APRIL 30, 1949		24c. NAME OF CEMETERY OR CREMATORY HIGHTNER CEM		24d. LOCATION (City, town, or county) (State) ILLMO, MO	
DATE REC'D BY LOCAL REG. 4-29-49		REGISTRAR'S SIGNATURE H. F. D. ... -300		25. FUNERAL DIRECTOR'S SIGNATURE Biggslinghoff Funeral Home		ADDRESS Illmo, Mo	

RECEIVED

District Health Office No. 2,

District File Number 549-570

Date Filed 2-3-48

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

William J. Smith

Signed _____

Student Embalmer

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.