

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31019

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 160

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chillicothe</u>	
c. LENGTH OF STAY (in this place) <u>16 days</u>		d. STREET ADDRESS (If rural, give location) <u>918 Calhoun</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe, Mo</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lillie</u>	b. (Middle) <u>May</u>	c. (Last) <u>Thompson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>9-20-50</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White US</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 18, 1870</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Calvin Berley Bills</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Usher</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Brookshire, Chillicothe, Mo</u>	ADDRESS _____
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>glaucoma kidney failure</u>		<u>4 days</u>
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Esoph. enterostomy performed on 11 Sept. 1950 for pyloric obstruction</u>			<u>545X</u>

19a. DATE OF OPERATION <u>11 Sept. 50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Obstruction, complete at pylorus, apparently seen from ulcer</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____	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 8 Sept., 1950, to 20 Sept., 1950, that I last saw the deceased alive on 19 Sept., 1950, and that death occurred at 3:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles M. Grace, M.D.</u>	23b. ADDRESS <u>Chillicothe, Mo.</u>	23c. DATE SIGNED <u>20 Sept. 1950</u>
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24a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-23-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lock Springs</u>	24d. LOCATION (City, town, or county) (State) <u>Lock Springs, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Sept-20-50</u>	REGISTRAR'S SIGNATURE <u>Trances B. Keel</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman Funerals Home</u>	ADDRESS <u>Chillicothe, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



NOV 1950

JAN 20 1959

JAN 21 1957

DEC 1 1950

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.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *Joseph M. Gibson*  
Licensed Embalmer No. *4769*

P. O. Address *Chillicothe, 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.