

FILED MAR 5 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5338

5644
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) Hannibal	
c. LENGTH OF STAY (In this place) 2/24/51		d. STREET ADDRESS (If rural, give location) 918 Center	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering			

3. NAME OF DECEASED a. (First) Lillian L. b. (Middle) Christian c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) February 24, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 27, 1875	9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) Hunnewell Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Albert G. Lyell		13b. MOTHER'S MAIDEN NAME Catherine Keith		14. NAME OF HUSBAND OR WIFE Robert E. Christian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Robert E. Christian	
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) Paroxysmal Ventricular Tachycardia			INTERVAL BETWEEN ONSET AND DEATH 48 hrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 241X		Interval between onset and death 2 weeks
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)	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 9-18-46, 1946, to 2-24-51, 1951, that I last saw the deceased alive on 2-24-51, 1951, and that death occurred at 3:15 P.m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title) M. D.	23b. ADDRESS 100 N. Sixth, Hannibal, Mo.	23c. DATE SIGNED 2-26-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2/2/6 1951	24c. NAME OF CEMETERY OR CREMATORY Mount Olivet	24d. LOCATION (City, town, or county) (State) Hannibal Missouri
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DATE REC'D BY LOCAL REG. 2-28-51	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS Hannibal Missouri
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(Licensed Embalmers' Statement on Reverse Side)

RECEIVED MAR 2 1951
HEALTH DEPT.
DATE FILED MAR 2 1951

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.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

H. Crawford Smith

Licensed Embalmer No. 3814

P. O. Address Hannibal 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.