

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34324**  
Registrar's No. **122**

FILED OCT 18 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **#198** PRIMARY REG. DIST. NO. **5740**

1. PLACE OF DEATH a. COUNTY <b>Macon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>	
b. CITY OR TOWN <b>Rural-Lingo township</b>		b. COUNTY <b>Macon</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY OR TOWN <b>Rural-Lingo township</b> <b>0610</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6 miles so. of New Cambria</b>		d. STREET ADDRESS (If rural, give location) <b>6 miles so. of New Cambria</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b>	b. (Middle) <b>John</b>	c. (Last) <b>Lloyd</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 6, 1951</b>
--	-------------------------	------------------------	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never married</b>	8. DATE OF BIRTH <b>Nov. 15, 1875</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>21</b>	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm owner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>New Cambria, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
---	---	---	--

13a. FATHER'S NAME <b>William W. Lloyd</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Roberts</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>No.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Kate Lloyd</b>	ADDRESS <b>New Cambria, Mo</b>
--	------------------------------------	--	--------------------------------

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, athenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic &amp; Hypertensive Heart Disease</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral Thrombosis</b>			

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 **July 17, 1951**, to **Oct. 6, 1951**, that I last saw the deceased alive on **Oct. 4, 1951**, and that death occurred at **4:20 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>James E. Campbell M.D.</b>	23b. ADDRESS <b>Macon Mo.</b>	23c. DATE SIGNED <b>10-9-51</b>
--	-------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-9-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cambria</b>	24d. LOCATION (City, town, or county) (State) <b>New Cambria, Mo.</b>
---	--------------------------	---	---

DATE REC'D BY LOCAL REG. <b>10-9-51</b>	REGISTRAR'S SIGNATURE <b>Josephine King</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>H.F. Hilleland</b>	ADDRESS <b>New Cambria, Mo.</b>
---	---	--	---------------------------------

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

610  
1

JUL 2 1951

RECEIVED 10.17.51  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 10.51.170  
Date Filed 10.17.51

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.

Student \_\_\_\_\_  
Student Embalmer

Signed H. J. Gilliland

Licensed Embalmer No. 4019

P. O. Address New Cambria 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.