

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **133707**

FILED OCT 18 1954

BIRTH NO. _____		REG. DIST. NO. 137		PRIMARY REG. DIST. NO. 4218		Registrar's No. 50	
1. PLACE OF DEATH a. COUNTY Henry				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Henry			
b. CITY (If outside corporate limits, write RURAL and give township) Windsor				c. CITY (If outside corporate limits, write RURAL and give township) Clinton			
d. FULL NAME OF HOSPITAL OR INSTITUTION Windsor Hospital				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) ELIZABETH MATILDA DILLEY				4. DATE OF DEATH (Month) (Day) (Year) Oct. 6, 1954			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Nov. 17, 1882	
9. AGE (In years last birthday) 71		10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Jama County Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Wilbur W. Ross		13b. MOTHER'S MAIDEN NAME Emma Winters		14. NAME OF HUSBAND OR WIFE Henry B. Dilley	
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 H.B. Dilley, Clinton, Mo. R7D			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Gall ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bladder with Metastasis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5 or 6 mo.	
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 22, 1954 , to Oct. 6, 1954 , that I last saw the deceased alive on Oct 6, 1954 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE Claude M. Thurber MD				23b. ADDRESS Windsor Mo		23c. DATE SIGNED 10-7-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-6-54		24c. NAME OF CEMETERY OR CREMATORY Lees Summit		24d. LOCATION (City, town, or county) (State) Lees Summit, Missouri	
DATE REC'D BY LOCAL REG. 10-6-54		REGISTRAR'S SIGNATURE Florence Adair		25. FUNERAL DIRECTOR'S SIGNATURE Lansford Funeral Home ADDRESS Lees Summit Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Thindoor, 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.