

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11427**

FILED APR 28 1955

BIRTH NO. _____ REG. DIST. NO. **98** PRIMARY REG. DIST. NO. **4160** Registrar's No. **53**

1. PLACE OF DEATH a. COUNTY Davens 0310		2. USUAL RESIDENCE (Where deceased lived. If institution: Address before admission) a. STATE Missouri b. COUNTY Davens	
b. CITY (If outside corporate limits, write RURAL and give township) Winston		c. CITY (If outside corporate limits, write RURAL and give township) Winston	
c. LENGTH OF STAY (In this place) years		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED a. (First) LILLIE b. (Middle) ROSE c. (Last) BAXTER			4. DATE OF DEATH APRIL-8-1955		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2	
8. DATE OF BIRTH JULY 22-1878		9. AGE (In years, months, days) 76		10. KIND OF BUSINESS OR INDUSTRY MO	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (City and State or Foreign Country) MO		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME JOHN COBB		13b. MOTHER'S MAIDEN NAME DOWNS		14. NAME OF HUSBAND OR WIFE Allen Beard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME L. Baxter Winston, 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) Myocarditis Chronic - Myocarditis		INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) hypertension & arteriosclerosis			
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)		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 1949**, to **April 8, 1955** that I last saw the deceased alive on **April 6, 1955**, and that death occurred at **8:15** m., from the causes and on the date stated above.

23a. SIGNATURE Fred Williams, M.D. (Degree or title)		23b. ADDRESS WINSTON, MO		23c. DATE SIGNED 4/2/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-10-55		24c. NAME OF CEMETERY OR CREMATORY Altavista	
				24d. LOCATION (City, town, or county) (State) Weatherly MO	

DATE REC'D BY LOCAL REG. 4-27-55		REGISTRAR'S SIGNATURE Virginia M. Engelhart		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate Shoup	
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

200 20

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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 *L. O. Richardson*

Licensed Embalmer No. *3302*

P. O. Address *Fullerton, Pa.*

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.