

10. 300
0. 48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37499

FILED DEC 1 1955

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 361

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Adams</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>	c. LENGTH OF STAY (In this place) <u>11 da</u>	c. CITY OR TOWN <u>Fall Creek</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>812 g</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lilly Lantry</u> b. (Middle) <u>Meyer</u> c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) <u>November 22, 1955</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 29, 1885</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>	IF UNDER 1 HR. Hours _____ Mins. _____
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 <u>XX</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Rockport Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			

13a. FATHER'S NAME <u>Andrew Fortner</u>	13b. MOTHER'S MAIDEN NAME <u>Eliza Drummond</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased - Dodds, Quincy Ill.</u>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lola P. Dodd Quincy Illinois</u>	ADDRESS <u>Quincy Illinois</u>
---	--	---	-----------------------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mths</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of abdomen cavity</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Primary Scl. Undetermined?</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1999</u>			

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 7-29-55, 1955, to 11-22-55, 1955, that I last saw the deceased alive on 11-22-55, and that death occurred at 4:30P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>[Signature]</u>	23b. ADDRESS <u>M.D. 100 N. Sixth, Hannibal, Mo.</u>	23c. DATE SIGNED <u>11-25-55</u>
--	---	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11/25/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Melrose Township Illinois</u>
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. <u>11-29-55</u>	REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke By W. T. Fisher</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Hannibal Mo</u>
---	---	--	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED NOV 29 1955
MARION CO. HEALTH DEPT.
DATE FILED NOV 29 1955

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.....
Signature of Student Embalmer

Signed *H. Campbell Smith*.....

Licensed Embalmer No..... 3814

P. O. Address .. Hannibal, Miss

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.