

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 10 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 93 PRIMARY REG. DIST. NO. 4154 Registrar's No. 56-12

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Greenfield Mo</u>		c. LENGTH OF STAY (in this place) <u>Yrs</u>	c. CITY OR TOWN <u>Greenfield Mo</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home Spring St</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) <u>Spring St</u>	

0290

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lillie</u> b. (Middle) <u>Ma e</u> c. (Last) <u>Starr</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 3 1956</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 10 1881</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Carthage Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	

13a. FATHER'S NAME <u>Jerry Swigert</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Ann Hannah</u>	14. NAME OF HUSBAND OR WIFE <u>Wilcox Starr</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>Elmo Starr</u>
		ADDRESS <u>Greenfield Mo.</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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>muscular dystrophy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>progressive temporal hemiparesis atrophy</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>7441</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 9-1, 1955, to Jan 3, 1956, that I last saw the deceased alive on 9-7, 1956, and that death occurred at 7:00a m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. O. Cowan M.D.</u>	(Degree or title)	23b. ADDRESS <u>Greenfield Mo 1-4-56</u>	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan 5, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>	24d. LOCATION (City, town, or county) (State) <u>Greenfield Mo</u>

DATE REC'D BY LOCAL REG. <u>1-5-56</u>	REGISTRAR'S SIGNATURE <u>J. C. Cowan 478</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Allison</u>	ADDRESS <u>Greenfield Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300  
0.48

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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.....  
Signature of Student Embalmer

Signed *W. R. Allison*

Licensed Embalmer No. *44*

P. O. Address *Albany*

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.