FILED JUL 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 021679
STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 71

1. PLACE OF DEATH
a. COUNTY Lafayette
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington — Inside Limits Yes ☐ X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lexington Memorial Hospital — Length of stay in 1b 5 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Lafayette
c. CITY OR TOWN Lexington — Inside Limits Yes ☐ X No ☐
d. STREET ADDRESS (If outside, give location) 1610 Bloom St. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First LILLIAN Middle I. Last HILLOCK

4. DATE OF DEATH Month Day Year June 11, 1957

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH November 30, 1878

9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (City and state or country) Mayview, Missouri.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe Schaal

14. MOTHER'S MAIDEN NAME Margaret Schlick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Address A.R. Hillock, Lexington, Mo.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH 8 days.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive heart disease

DUE TO (c) decompensation.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 4/57, to June 11/57 and last saw her/him alive on June 11/57
Death occurred at 6:15 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) B. Payne M.D.

22b. ADDRESS Lexington Mo

22c. DATE SIGNED 7-7-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE June 13, 1957

23c. NAME OF CEMETERY OR CREMATORY Memorial Park

23d. LOCATION (City, town, or county) (State) Lexington, Missouri.

24. FUNERAL DIRECTOR Forrest F. Tempel — **ADDRESS** Lexington Missouri

25. DATE RECD. BY LOCAL REG. 7-9-57

26. REGISTRAR'S SIGNATURE Minerva E. Eastabrook

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision.:

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.