

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019030
STATE FILE NUMBER

FILED MAY 22 1958 Registration District No. 211 Primary Registration District No. 4324 Registrar's No. 12-58

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Miller | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Miller | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-Blaze | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Kaiser |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kami-N-E-Kaiser | | Length of stay in lb 5 yrs | d. STREET ADDRESS (If outside, give location) 1 1/2 mi - N-E - Kaiser |
| | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|------------------------|---|---|-------------------------------------|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last LIZZIE ELLEN BILYEU | | | 4. DATE OF DEATH Month Day Year MAY-10-1958 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 August-1892 | 9. AGE (In years last birthday) 65 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY AT-Home | 11. BIRTHPLACE (City and state or country) Miller-Co-Mo | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME FRANCIS-Kaiser | | 13b. MOTHER'S MAIDEN NAME KATHERYN-Byrd | | 14. NAME OF HUSBAND OR WIFE Denver-Bilyeu | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT FINIS-Bilyeu | |

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|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE | | | INTERVAL BETWEEN ONSET AND DEATH 6 DAYS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ | | | 331X |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|--|---|--|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) NONE | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. NONE | | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | |

| | | | | | |
|--|--|-----------------------------------|--|--------------|--|
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. CITY, TOWN, OR LOCATION NONE | | COUNTY STATE | |
| 21. I attended the deceased from 3-28-58 to 5-10-58 and last saw her alive on 5-9-58 | | | | | |
| Death occurred at 6:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |

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|--|--|-----------------------------|--|---|--|
| 22a. SIGNATURE L.S. Humphrey D.O. 2 | | 22b. ADDRESS Tusculumbia-Mo | | 22c. DATE SIGNED 5-10-58 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 12 MAY-1958 | | 23c. NAME OF CEMETERY OR CREMATORY New-Hope | |
| | | | | 23d. LOCATION (City, town, or county) Kaiser-Mo | |

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|---|--|------------------|--|--|--|
| 24. FUNERAL DIRECTOR Keith M. Kaye | | ADDRESS Eldon-Mo | | 25. DATE RECD. BY LOCAL REG. 5-12-1958 | |
| 26. REGISTRAR'S SIGNATURE Mrs. W. E. Kallenbach | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

MEDICAL CERTIFICATION

RECEIVED

MAY 19 58

**Miller County
Health Department**

APR 25 1961

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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 *Keith M. Kays*

Licensed Embalmer No. *3998*

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