

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015318  
STATE FILE NUMBER

FILED APR 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **23515**

Health, Welfare, Public Service  
300  
1-56  
69  
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Disease in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
Disease in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in 1b	d. STREET ADDRESS <b>1391 Blackstone</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle Last <b>Lillard</b>			4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>59</b>		
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-59</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days <b>6 32</b> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Saint Louis, Missouri</b>	
13. FATHER'S NAME <b>Jasper Lillard</b>			14. MOTHER'S MAIDEN NAME <b>Christine Robertson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address <b>2601 N. Whittier</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth, Neonatal death</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>773.5</b>					
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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>3-31-59</b> to <b>3-31-59</b> and last saw her <sup>her</sup> <del>her</del> alive on <b>3-31-59</b> Death occurred at <b>8:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Nancy L. Lillard, M.D.</b> (Degree or title)			22b. ADDRESS <b>2601 N. Whittier</b>		22c. DATE SIGNED <b>4-6-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4-30-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Rowland Aker 4104 Manchester</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>APR 9 '59</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>

**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.....

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.