

Department of Health,
S. & Welfare
S. Public
Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022144
STATE FILE NUMBER

New JUL 13 1959 Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 110

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon		c. CITY OR TOWN New Cambria	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 409 Pearl St.		d. STREET ADDRESS 4 mi. S. New Cambria	
Length of stay in lb 5 mo.		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARY Middle ELLA Last LLOYD			4. DATE OF DEATH Month June Day 19 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1887	9. AGE (In years last birthday) 71	FUNDER 1 YEAR Months 9 Days 22	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Own home.	11. BIRTHPLACE (City and state or country) New Cambria, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William Lloyd	13b. MOTHER'S MAIDEN NAME Catherine Roberts	14. NAME OF HUSBAND OR WIFE No.
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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. No.	17. INFORMANT 409 Pearl St. Miss Kate Lloyd Macon, Mo.
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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) Carcinoma of Stomach		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from Intervals since 1957 to June 18 and last saw her alive on June 18 Death occurred at 6:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) James E. Campbell M.D.	22b. ADDRESS James E. Campbell Macon Mo	22c. DATE SIGNED 6/20/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 21, 1959	23c. NAME OF CEMETERY OR CREMATORY New Cambria Cemetery	23d. LOCATION (City, town, or county) (State) New Cambria, Mo.
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24. FUNERAL DIRECTOR H. E. Hilliard	ADDRESS New Cambria Mo	25. DATE RECD. BY LOCAL REG. June 20, 1959	26. REGISTRAR'S SIGNATURE Ruth McNeely
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(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

S. 300

v. 1-57

JUL 13 1958

County File No.
Date Filed 7-10-59

FEB 2 1960

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. J. Lilleland* _____

Licensed Embalmer No. *4019* _____
P. O. Address *New Columbia* _____

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.