

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

4433

**PLACE OF DEATH**

County Cott  
 Township Valerie  
 City Jefferson (No. 3733)

Registration District No. 3733

Primary Registration District No. 3733

File No. 16  
 Registered No. 16  
 St. Ward

**2. FULL NAME**

(a) Residence. No. Leota Gertrude Lilly St. Ward Ward  
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Fem. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W K Lilly

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20, 1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
47 7 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Browning (STATE OR COUNTRY) Mo

10. NAME OF FATHER Norman Neely

11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Virginia (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Henrietta Cassidy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milan (STATE OR COUNTRY) Mo.

14. INFORMANT W K Lilly (Address) Ward

15. FILED 3-2 19 30 Belle Haynes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1930, to Feb 28 1930 that I last saw him alive on 2/26 1930, and that death occurred, on the date stated above, at 5:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Shock following operation  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Infected Gall-bladder  
 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2/26/30  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs  
 (Signed) S. S. Waller M. D.  
 19 30 (Address) Eldon Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brookfield Linn. Co., Mo DATE OF BURIAL 3-2 19 30

20. UNDERTAKER W A Phillips ADDRESS Eldon Mo

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**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Cole  
Township Clark  
City Etterville (No. 1)

Registration District No. 212  
Primary Registration District No. 5292

File No. 16  
Registered No. 16  
St. 1 Ward 1

**2. FULL NAME**

(a) Residence. No. 1 St. 1 Ward 1  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. K. Lilly

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 7 8

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Browning  
(STATE OR COUNTRY) mo

10. NAME OF FATHER Norman Lilly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Haynes  
(STATE OR COUNTRY) mo

12. MAIDEN NAME OF MOTHER Jessieetta Cassity

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milan  
(STATE OR COUNTRY) mo

14. INFORMANT W. K. Lilly  
(Address) Etterville mo

15. FILED 3-2 30 Belle Haynes  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930

17. I HEREBY CERTIFY That I attended deceased from Jan 18 1930 to Feb 28 1930  
that I last saw him alive on 2/26, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septic following  
operation  
(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Infected gall bladder  
Gall stones  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 23  
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? yes DATE OF 2/26/30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical signs  
(Signed) L. D. Walker, M. D.  
(Address) Eldon mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brookfield Linn Co. mo DATE OF BURIAL 3-2 1930

20. UNDERTAKER W. A. Phillips ADDRESS Eldon mo

GISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY BOARD

5-5708-A