

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

Do not use this space.

20726

1. PLACE OF DEATH

County Buchanan
Township
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
No. 623 Roy Street

File No.
Registered No. 745
St. Ward)

2. FULL NAME Lilly Wilson
(a) Residence, No. 623 Roy Street St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 72 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) Widowed.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 6, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 3 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ray County
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Don Cluck

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Josephine Shepard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs. San Creal
(Address) 1920 Delmar Street

15. FILED John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25, 1927

17. I HEREBY CERTIFY That I attended deceased from July 18, 1927 to July 25, 1927 that I last saw her alive on July 23, 1927, and that death occurred, on the date stated above, at 6:30 Am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fractured Hip - left
Accidental fall
out of bed
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
Uremia (duration) 7 yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, DATE OF

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? Exam. & X-Rays
(Signed) G. F. Bloomer, M. D.

7/26, 1927 (Address) 1218 N. 3rd St.

*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 DATE OF BURIAL

Mount Auburn Cemetery July 27, 1927
20. UNDERTAKER ADDRESS

H. O. Sidenfader 1802 Union St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

UG 16 1927

