

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

Do not use this space.

OCT 31 1930

30926

773
6018A

File No. _____
Registered No. 138 Ward _____

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Farmington, Mo. (No. _____)

Registration District No. _____
Primary Registration District No. 6018A

2. FULL NAME Lily O'Well

(a) Residence. No. Ruble, Mo. St. _____ 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 Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 2 9

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) (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Records (Address) Farmington, Mo.

15. FILED 9-19-30 T. J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Sept 18, 1930, that I last saw her alive on Sept 18, 1930, and that death occurred, on the date stated above, at 6:20 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
(duration) yrs. mos. 1 ds.

CONTRIBUTORY Fracture of right tibia & fibula. Accidental, due to fall.
(SECONDARY) (duration) yrs. mos. 4 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) J. C. Fincher, M. D.

Sept 19 1930 (Address) Farmington, 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 Hospital Cemetery **DATE OF BURIAL** 9-19 1930

20. UNDERTAKER Hospital No 4 **ADDRESS** Farmington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 St. Francois Registration District No. 773 File No. _____
 Township _____ Primary Registration District No. 60180 Registered No. 138
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Lily Dell
 (a) Residence. No. _____ St. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

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

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address) _____

15. FILED 11-15-30 F. J. Robinson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1930
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

CONTRIBUTORY (SECONDARY) fracture of right tibia & fibula due to fall
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at State Hospital #4
(duration) yrs. mos. ds.
 IF NOT AT PLACE OF DEATH patient fell backwards over a floor polisher pushed by another patient
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) J. C. Fincher, M. D.
Nov. 17, 1930 (Address) Farmington 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 _____ DATE OF BURIAL _____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL RECEIVE A FEE FOR THIS SUPPLEMENTARY UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B. This information should be carefully read. PHYSICIAN should be stated EXACTLY. CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important.

S-30926