

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11207

State File No.

FILED APR 12 1944

Registration District No. 1584

Primary Registration District No. 3127

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 846 So. Ball
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community 15 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City or town Webb City
(If outside city or town limits, write "RURAL")

(d) Street No. 846 So. Ball
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Lillian Marie Black

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1944 hour 12:30 minute..... A. M.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased December 4 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 13 1940 to March 6 1944
that I last saw her alive on March 5 1944
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>3</u>	<u>2</u>	hr. min.

Immediate cause of death Renal by metastasis Nephritis

Due to.....

Due to.....

9. Birthplace Johnstown Penna.
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

11. Industry or business.....

12. Name John Black

13. Birthplace No data 9
(City, town, or county) (State or foreign country)

14. Maiden name Edith Lipe

15. Birthplace No data 9
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

1312

16. (a) Informant Dr. Edith Conner

(b) Address Chicago, Ill

17. (a) Burial (b) Date thereof 3/11/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

18. (a) Signature of funeral director W. J. Melton
(b) Address Webb City, Mo

19. (a) Mar 11, 1944 (b) W. J. Melton
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature W. J. Melton (M. D. or other)
Address Webb City, Mo Date signed 3/6/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

19
6
2

MOTHER FATHER

44-3-303

Statement

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.....
....., Registered Apprentice No.....
working under my personal supervision..

Signed..... *E. W. Hedge*
Licensed Embalmer No. *2859*
P. O. Address *1116 1/2 St. N. W.*

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 this body is not embalmed, fact should be so stated above.