

FILED FEB 13 1945  
Registration District No. 177

Primary Registration District No. 3025 Registrar's No. 8

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 20 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. County Howell  
(b) City or town West Plains  
(If outside city or town limits, write "RURAL")  
(c) Street No. \_\_\_\_\_ (If rural, give location)  
(d) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Turkey Lile  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 16  
year 44 hour 12 minute 20 a.m.

21. I hereby certify that I attended the deceased from over Mar. 15, 1944, to Dec. 12, 1944; that I last saw him alive on Dec 2, 1944 and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife Oranah Lile 6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased June 7 - 1880  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Hemorrhage (Apoplexy) Myocarditis Chronic

8. AGE: Years 60 Months 4 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 93d

9. Birthplace Christian Co., Ky. (City, town, or county) (State or foreign country)  
10. Usual occupation Machinist

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name W. P. Lile  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)  
14. Maiden name Oranah Lile  
15. Birthplace Ky. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs P. Lile  
(b) Address West Plains Mo.  
17. (a) \_\_\_\_\_ (b) Date thereof 12-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Lawn

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. P. Lile  
(b) Address West Plains Mo.  
19. (a) 12-30-45 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. P. Lile (M. D. or other) 1/11/44  
Address West Plains, Mo. Date signed \_\_\_\_\_

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

H6

RECEIVED

Coroner Health Officer No. 5,

District File Number 24558

Date Filed 2, 8-45.

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 D. L. Roberts

Licensed Embalmer No. 3437

P. O. Address West Plains, Mo

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.