

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 105-7

FILED FEB 19 1945

Registration District No. _____

Primary Registration District No. 5663

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Lewis
(b) City or town Rural Lyon Twp
(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)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Louisa Hannah Bishoff
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F. W. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter E. Bishoff 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased July 12 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Shelby County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

12. Name William Carlisle
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Narcissus Lillard
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Etta V. Nelson
(b) Address Williamstown Mo

17. (a) Burial (b) Date thereof 1-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Residence Cemetery

18. (a) Signature of funeral director Fred J. Kaele
(b) Address Hopkirk Mo.

19. (a) Feb. 3, 1945 (b) P. W. Jennings, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis
(c) City or town Rural Lyon Twp 56
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28th
year 1945 hour 9 minute 30 A.M.
21. I hereby certify that I attended the deceased from Jan. 10,
1945, to Jan 28 1945;
that I last saw her alive on Jan. 28 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Liver Duration 2 yrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 463

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature Ch. C. E. Todd (M.D. or other) D.D.

Address Williamstown Mo Date signed 2/1/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

57600

MAR - 8 1945

RECEIVED

District Health Officer No. 1

District File Number 2-45-365

Date Filed FEB 16 1945

MAR - 8 1945

OCT 27 1945

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 Fred Karle

Licensed Embalmer No. 1023

P. O. Address Kahoka 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.