

FILED JAN 21 1946

Registration District No. _____

Primary Registration District No. **3008**

Registrar's No. **98**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirkville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1103 W. George**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None** (Specify whether
In this community **Live**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Kirkville**
(If outside city or town limits, write "RURAL")
(d) Street No. **1103 W. George**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Lillie Maude Scofield**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **W. O. Scofield** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **Feb. 25 1878**
(Month) (Day) (Year)

8. AGE: Years **67** Months **9** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **Greencastle Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **John Steele**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **W. O. Scofield**
(b) Address **Kirkville, Mo**

17. (a) **Burial** (b) Date thereof **12/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Highland Park Cmt.**

18. (a) Signature of funeral director **D. E. Kelly**
(b) Address **Kirkville Mo**
19. (a) **12 31-45** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **15**
year **1945** hour **9:00** minute **P: M.**

21. I hereby certify that I attended the deceased from **12-10-45**
19____ to **12-14** 19**45**

that I last saw her alive on **12-14-45** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocardial Failure
Chronic Arterial Hypertension

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **102**
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 **Gullent H. Morgan** (M. D. or other) **D.O.**
Address **Kirkville Mo** Date signed **12/20/45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100020

JAN 25 1946

RECEIVED

District Health Officer No. 10

District File Number 1-46-11

Date Filed JAN 16 1946

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. E. Riley

Licensed Embalmer No. 4181

P. O. Address Hot Springsville, W. Va.

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.