

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

113246  
State File No.

FILED APR 20 1948

Registration District No. 213

Primary Registration District No. 5655

Registrar's No. 51

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Mt. Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 245 days  
In this community 245 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Liley May Wilson  
3. (b) If veteran, name war no  
3. (c) Social Security No. 490-28-9872

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Eulas G. Wilson  
6. (c) Age of husband or wife if alive 34 years  
7. Birth date of deceased July 20 1916  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
31 8 24 hr. min.

9. Birthplace Unknown Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Stewart E. Kemp  
13. Birthplace Alcorn County Miss.  
(City, town, or county) (State or foreign country)  
14. Maiden name Famie Lewis  
15. Birthplace Alcorn County Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof 4/13/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter Mo.

18. (a) Signature of funeral director Walter's Fun Home

(b) Address Dexter Mo.

19. (a) 4-10-48 (b) Cecil Hendricks  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County New Madrid 72  
(c) City or town Risco  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th  
year 1948 hour 10:38 minute 4 M.

21. I hereby certify that I attended the deceased from July 11, 1947 to April 13, 1948  
that I last saw her alive on April 13, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis  
Duration Abt 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 19  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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)  
(c) Means of injury 0

23. Signature C. E. Bellweg M.D. (M. D. or other)  
Address Mt. Vernon, Mo. Date signed 4-13-48

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

JUL 22 1946

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**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: *George B. Orr*

Licensed Embalmer No. *946*

P. O. Address: *Mr. Vernon D.*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *may*  
Registrar's No. *5-1*

Registration District No. *383*

Primary Registration District No. *5655*

1. PLACE OF DEATH

(a) County *Lawrence*  
(b) City or town *not known*  
(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 *Lily M. Wilson*  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *M*

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

7. Birth date of deceased *July 20*  
(Month) (Day) (Year)

8. AGE: Years *31* Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *4-15-48* (b) *Cecil Hendrick*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *July* Year *1948* Hour *3* minute M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death.

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY 3

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

S-13246