

Dr. Dills.  
FILED NOV 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33600

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 985

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>	
c. LENGTH OF STAY (In this place) <b>60 Yrs</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>615 S. Douglas</b>	

3. NAME OF DECEASED (Type or Print) <b>Lillie May</b>	a. (First)	b. (Middle)	c. (Last) <b>Sackett</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 9 1949</b>
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5. SEX <b>F M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Feb. 1, 1877</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>8</b> Days	IF UNDER 2 HRS. Hours <b>8</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Dwajack, Mich /</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Benjamin Hamilton</b>	13b. MOTHER'S MAIDEN NAME <b>Naoma Marr</b>	14. NAME OF HUSBAND OR WIFE <b>(Deceased)</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Velma Sullivan, Clever, #</b>	MO. ADDRESS <b>#####</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adeno Carcinoma - ovary</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>175X</b>	

19a. DATE OF OPERATION <b>11-4-49</b>	19b. MAJOR FINDINGS OF OPERATION <b>Carcinomatosis -</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **July**, 19**49**, to **Nov 9**, 19**49**, that I last saw the deceased alive on **Nov. 9**, 19**49**, and that death occurred at **11 A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph N. Hill M.D.</b> (Degree or title)	23b. ADDRESS <b>609 Cherry Springfield, Mo</b>	23c. DATE SIGNED <b>11-10-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11-13-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Payne</b>	24d. LOCATION (City, town, or county) (State) <b>Near Springfield, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>11-12-49</b>	REGISTRAR'S SIGNATURE <b>W.E. Handley, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W.L. Lunn</b> ADDRESS <b>Springfield, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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NOV 22 1949

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *H. J. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield 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.