

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40983  
STATE FILE NUMBER

FILED NOV 25 1957

172

4272

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Lafayette</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Waverly</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Waverly Rt. #1</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Kelling Clinic</b>		Length of stay in lb <b>2 weeks</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>E.</b> Last <b>TRUX Tice</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/15/1875</b>
9. AGE (In years birth-day) <b>82</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of adult life, except if retired) <b>post mistress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>post office</b>	11. BIRTHPLACE (City and state or country) <b>Lafayette Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Lafayette Tice</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Walter</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Bessie Kirschner-Hodge, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>11/8/57</b> <b>11/21/57</b> <b>abt. 2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>hypertension with arteriosclerosis</b>			331X
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ o.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1909</b> to <b>11/21/57</b> and last saw her alive on <b>11/21/57</b> Death occurred at <b>4:15</b> A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>George A. Kelling MD</b>		22b. ADDRESS <b>Waverly, Missouri</b>	22c. DATE SIGNED <b>11/22/57</b>
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <b>11/23/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>4 Mi. W. Waverly, Mo.</b>
24. FUNERAL DIRECTOR <b>Bailey Funeral Home-Waverly, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-22-1957</b>	26. REGISTRAR'S SIGNATURE <b>Manuel Bailey</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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MAR 5 1958

FEB 28 1958

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Morris D. Bailey*

Licensed Embalmer No. *4887*

P. O. Address *Waverly, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.