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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021151
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 143 Primary Registration District No. 4231 Registrar's No. 37

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Mountain View — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Howell
c. CITY OR TOWN: Mountain View — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 0/6 0 0 — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Lillie Middle: L. Last: Richardson

4. DATE OF DEATH Month: June Day: 7 Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 4, 1890

9. AGE (If years, last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Melbourn, Ark.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Bill Billingsley

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Don Richardson Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lungs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Chronic bronchitis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 163X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 28, to June 7 and last saw her/him alive on June 4
Death occurred at 5:20 P. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.C. Walton M.D.

22b. ADDRESS: Willow Springs Mo

22c. DATE SIGNED: 6-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 6/10/59

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn

23d. LOCATION (City, town, or county) (State): Mountain View, Missouri

24. FUNERAL DIRECTOR ADDRESS: Duncan Funeral Home, Mtn. View, Mo.

25. DATE RECD. BY LOCAL REG.: 6-20-59

26. REGISTRAR'S SIGNATURE: Laura Mitchell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JUL 20 1959

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 Richard A. Norton

Licensed Embalmer No. 5029

P. O. Address Mt. Vernon

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.