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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED AUG 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29258

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 7518

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital, O  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30  
(c) City or town Buffalo 001  
(If outside city or town limits, write "RURAL")  
(d) Street No. N.R. (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5  
year 1947 hour 11 minute 15 a. M.  
21. I hereby certify that I attended the deceased from  
July 29, 1947, 19\_\_\_\_, to August 5, 1947, 19\_\_\_\_;  
that I last saw her alive on August 5, 1947, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Carcinoma of pancreas  
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.

3. (a) PRINT FULL NAME Ada Marie Lillegard  
3. (b) If veteran, name war No 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 Virgil Lillegard 6. (c) Age of husband or wife if alive 32 years  
7. Birth date of deceased February 1 1916  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
31 7 4 hr. min.

9. Birthplace Dallas Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name A.M. Newport

13. Birthplace Dallas Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Rosa Cassity

15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Virgil Lillegard

(b) Address Buffalo, Mo.

17. (a) Burial (b) Date thereof 8-8-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo, Mo.

18. (a) Signature of funeral director Albert H. Hoppe  
(b) AUG 8 1947 4700 Washington Blvd

19. (a) \_\_\_\_\_ (b) J. B. Bueck  
(Data received local registrar) (Registrar's signature)

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 \_\_\_\_\_ 0  
23. Signature F.R. Bradley (M. D. or N.D.)  
Address Barnes Hospital Date signed 8/5/47

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

SEP 2 1947

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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..... *J. Allen Davis* .....

Licensed Embalmer No. *4053* .....

P. O. Address..... *St. Louis* .....

**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.**