

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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1120 100

PLACE OF DEATH

County Cott
 Township Valerie
 City Jefferson (No. _____)

Registration District No. 3-2
 Primary Registration District No. 3-733 a

File No. _____
 Registered No. 16
 St. _____ Ward _____

2. FULL NAME Leota Gertrude Lilly
 (a) Residence. No. Letterville Mo St. _____ Ward. Letterville Mo
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. ____ mo. ____ da. How long in U. S., if of foreign birth? yrs. ____ mo. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE white
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W K Lilly
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20, 1882
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
47 7 8
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Browning Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Norman Neely
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Virginia
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Amrietta Cassey
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milan Mo.
 (STATE OR COUNTRY)

14. INFORMANT W K Lilly
 (Address) Letterville

15. FILED 3-2 1930 Belle Haynes
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930
 17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1930 to Feb 28 1930
 that I last saw him alive on 2/26 1930, and that death occurred, on the date stated above, at 5:30 a. m.

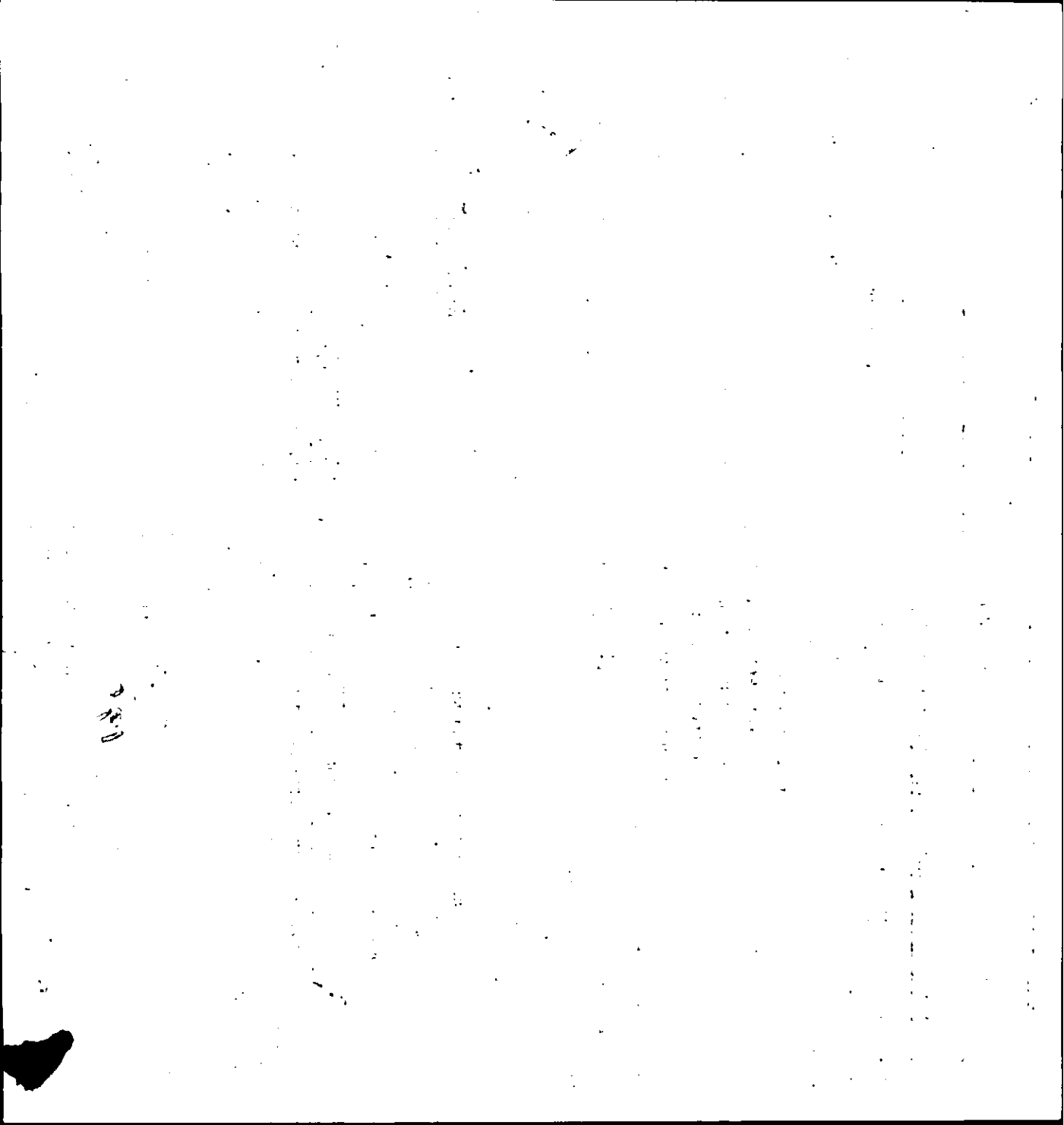
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock following operat
 (duration) ____ yrs. ____ mo. ____ ds.
 CONTRIBUTORY (SECONDARY) I infected Gall-bladder
 (duration) 2 yrs. ____ mo. ____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? yes DATE OF 2/26/30
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical Signs
 (Signed) S J Walker, M. D.
 . 19 ____ (Address) Eldon Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brookfield Lin. Co., Mo DATE OF BURIAL 3-2 1930

20. UNDERTAKER W A Phillips ADDRESS Eldon Mo



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Boone Registration District No. 212 File No. _____
 Township Clark Primary Registration District No. 5-292 Registered No. 16
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

*(a) Residence No. Leota Gertrude Lilly St. _____ Ward Etterville mo
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. K. Lilly
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 - 1882
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 7 8

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Browning (STATE OR COUNTRY) mo

10. NAME OF FATHER Norman Lilly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Haynes (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Faustetta Cassity

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Milan (STATE OR COUNTRY) mo

14. INFORMANT W. K. Lilly (Address) Etterville mo

15. FILED 3-2 30 Belle Haynes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 28 1930
 17. I HEREBY CERTIFY That I attended deceased from Jan 10 to Feb 28 19 30
 that I last saw him/her alive on 2/26, 19 30, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock following operation
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY (SECONDARY) Infected gall bladder
Gall stones (duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED? 23
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF _____ 2/26/30
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical signs
 (Signed) L. D. Walker, M. D.
 .19 (Address) Eldon mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brookfield Linn Co. mo DATE OF BURIAL 3-2 1930

20. UNDERTAKER W. A. Phillips ADDRESS Eldon mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAWS

SUPPLEMENTARY

5-5708-A