No. 2
5-42
17-39

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29154

FILED SEP 8 1943

Registration District No. 298

Primary Registration District No. 6023

Registrar's No. 19

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Rayville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ~ 1 Richmond Ho
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community All his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County 0
(c) City or town 0 (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No) 0
If yes, name country.....

3. (a) PRINT FULL NAME James Henry Lile
3. (b) If veteran, name war ~ 3. (c) Social Security No. ~

4. Sex M | 5. Color or race Wh. | 6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife Linda Lile | 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Oct. (Month) 6. (Day) 1879 (Year)

8. AGE: Years 63 | Months 10 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Ray Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation Merchant.

11. Industry or business.....

MOTHER FATHER
12. Name Wylie Lile
13. Birthplace Mo (City, town, or county) 0 (State or foreign country)
14. Maiden name Mary Kincaid
15. Birthplace Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant David Lile
(b) Address Rayville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-43 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Kincaid Cemetery

18. (a) Signature of funeral director Alspaugh & Cowley
(b) Address Polo Mo

19. (a) 8-19-43 (Date received local registrar) (b) Wascent (Registrar's signature)

1145

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16
year 1943 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from July 20, 1943, to Aug 16, 1943, that I last saw him alive on Aug 14, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 wk.
Due to: advanced Arteriosclerosis	
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.

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? (Specify type of place)
While at work? (e) Means of injury.....

23. Signature Gil Gaines (M. D. or other)
Address Richmond, Mo. Date signed 8-19-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 9-7-43

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 A A Bowley

Licensed Embalmer No. 1015

P. O. Address Polo Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M---5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 298 Primary Registration District No. 6023 Registrar's No. 19

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Kansville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray
(c) City or town Kansville
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James Henry Lile
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive (Years)
7. Birth date of deceased Oct 6 67 (Month) (Day) (Year)
8. AGE: Years 63 Months 1 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Wa Black (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 6 year 1943 hour PM minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed