

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

1 PLACE OF DEATH

County *Ray*

Township *Orrick*

Village

City

Registration District No. *744*

Primary Registration District No. *5978*

File No.

Registered No. *305*

2172

2 FULL NAME

*Stanton Robert Lillard*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 SINGLE MARRIED WIDOWED OR DIVORCED *married*  
(Write the word)

6 DATE OF BIRTH *May - 8 - 1834*  
(Month) (Day) (Year)

7 AGE *80* yrs. *8* mos. *1* ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Farming* (b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) *Virginia*

PARENTS 10 NAME OF FATHER *George Lillard* 11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Virginia* 12 MAIDEN NAME OF MOTHER *Marile Lillard* 13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Virginia*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Harry D. Lillard* (Address) *Richmond Mo*

15 Filed *Jan 10<sup>th</sup>* 1915 *Geo W. Stout* Registrar *Deputy*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan - 9 - 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *December* 1914, to *January 9* 1915, that I last saw him alive on *Jan 8* 1915, and that death occurred, on the date stated above, at *9 a* m. The CAUSE OF DEATH\* was as follows:

*Chorea*  
*Chorea*  
*Chorea*  
CONTRIBUTORY (Secondary) *Chorea*  
(Duration) *15* mos. *15* ds.?  
(Signed) *Robert Shutz* M. D.  
*Jan 25, 1915* (Address) *Orrick Mo*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.  
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.  
Where was disease contracted if not at place of death?  
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL *New Hope Cemetery* DATE OF BURIAL *1-10, 1915*  
20 UNDERTAKER *H. S. Rowland* ADDRESS *Orrick Mo*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, icterus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

County Lay  
Township Orfick Registration District No. 743 File No. \_\_\_\_\_  
Village \_\_\_\_\_ Primary Registration District No. 5978 Registered No. 311  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

FULL NAME Stanton Robert Lillard (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W. SINGLE MARRIED WIDOWED OR DIVORCED Married (Write the word)

DATE OF DEATH Jan. 9, 1915  
(Month) (Day) (Year)

DATE OF BIRTH May. 8, 1834  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 1915, to Jan. 9, 1915, that I last saw him alive on " 8, 1915, and that death occurred, on the date stated above, at 9 a.m.

AGE 80 yrs. 8 mos. 1 ds. If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

THE CAUSE OF DEATH\* was as follows:  
pneumonitis et myocarditis

OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

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BIRTHPLACE (City or town, State or foreign country) Va.

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. 15 ds.

NAME OF FATHER George Lillard

Contributory Chron. Bronchitis  
(SECONDARY) (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Va.

(Signed) Robt Shutz M. D.  
Jan 25, 1915 (Address) Orfick Mo.

MAIDEN NAME OF MOTHER Maude Lillard

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harry Lillard

Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence. \_\_\_\_\_

(ADDRESS) Richmond Mo.

PLACE OF BURIAL OR REMOVAL New Hope Cem. DATE OF BURIAL 1-10, 1915

Filed Mar 3, 1915 L. E. Ellis REGISTRAR

UNDERTAKER F. S. Howland ADDRESS Orfick Mo.

BY DEPARTMENTAL ORDER, the following information is being furnished to you for your information. It is not to be used for any other purpose. It is not to be published. It is not to be used for any other purpose. It is not to be published. It is not to be used for any other purpose. It is not to be published.

MISSOURI STATE BOARD OF HEALTH  
SUPPLEMENTARY CERTIFICATE

# Revised United States Standard Certificate of Death

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