

175-1-0-2-175-1-0

 TEXAS DEPARTMENT OF HEALTH ¹⁵⁶⁻¹⁷
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

STATE OF TEXAS

STATE FILE NO.

60074

NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE

1. PLACE OF DEATH a. COUNTY Navarro		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission). a. STATE Texas b. COUNTY Navarro	
b. CITY (If outside corporate limits, write RURAL and give precinct no.) Corsicana		c. CITY (If outside corporate limits, write RURAL and give precinct no.) Corsicana	
d. FULL NAME OF HOSPITAL OR INSTITUTION P. & S. Hospital		d. STREET ADDRESS (If rural, give location) 720 South Main	
3. NAME OF DECEASED (Type or Print) a. (First) Lillie b. (Middle) May c. (Last) Head		4. DATE OF DEATH 12-26-1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9-25-1880
10a. USUAL OCCUPATION (Give kind of work done during most of preceding life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME John R. Sawyer		13. MOTHER'S MAIDEN NAME Unknown	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO.	
17. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Liver INTERVAL BETWEEN ONSET AND DEATH 4 Mo II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT SUICIDE HOMICIDE (Specify)		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20c. (CITY, TOWN, OR PRECINCT NO.) (COUNTY) (STATE)		19. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I hereby certify that I attended the deceased from 12/21, 1950 , to 12/26, 1950 , that I last saw the deceased alive on 12/26, 1950 , and that death occurred at 11 P. m. , from the causes and on the date stated above.		TEXAS DEPARTMENT OF HEALTH REC'D JAN 12 1951 BUREAU OF VITAL STATISTICS	
22a. SIGNATURE (Degree or title) W. W. Carter, M.D.		22b. ADDRESS Corsicana	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-26-1950	
23c. NAME OF CEMETERY OR CREMATORY Board Bros Cemetery (Union High)		24. FUNERAL DIRECTOR'S SIGNATURE W. W. Carter	
25a. REGISTRAR'S FILE NO. 274		25b. DATE REC'D BY LOCAL REGISTRAR 1-6-1951	
25c. REGISTRAR'S SIGNATURE W. W. Carter			