

FILED DEC 10 1947  
Registration District No. **1796**

Primary Registration District No. **1796**

Registrar's No. **74**

1. PLACE OF DEATH:

(a) County **Moniteau Co.**  
(b) City or town **Rural Walker**  
(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)

3. (a) PRINT FULL NAME **LILLIAN MYRTLE HOBACK**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Albert Hoback** 6. (c) Age of husband or wife if alive **60** years  
7. Birth date of deceased **Feb 2 1988**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**59 9 24** hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business **Erwin Deering**

12. Name **Moniteau Mo.**

13. Birthplace **Moniteau Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Wagon M. Daniel**

15. Birthplace **Chapin Co. Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Albert Hoback**

(b) Address **California Mo.**

17. (a) **Buried** (b) Date thereof **11-29-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Masonic Burial Cal. Mo.**

18. (a) Signature of funeral director **Hugh E. Williams**

(b) Address **California Mo.**

19. (a) **12-1-47** (b) **H. R. Poppey**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Moniteau**  
(c) City or town **Rural Walker**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **26**  
year **1947** hour **11** minute **P** M.

21. I hereby certify that I attended the deceased from **Jan 3**  
19 **47** to **Nov 26** 19 **47**;  
that I last saw her alive on **Nov 26** 19 **47**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis and cardiac insufficiency**  
Due to **3 years**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature **Kernon Latham** (M. D. or other) **11-29-47**  
Address **California, Mo.** Date signed

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 12-9-47

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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..... *Hugh E. Williams*.....  
Licensed Embalmer No..... *3537*.....  
P. O. Address..... *California Mo.*.....

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.