

WHEN THIS COPY CARRIES THE RAISED SEAL OF THE NEBRASKA STATE DEPARTMENT OF HEALTH, IT CERTIFIES THE BELOW TO BE A TRUE COPY OF AN ORIGINAL RECORD ON FILE WITH THE STATE DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS, WHICH IS THE LEGAL DEPOSITORY FOR VITAL RECORDS.

ISSUED Oct. 6, 1976
LINCOLN, NEBRASKA

Freda Sheis
DIRECTOR OF VITAL STATISTICS

STATE OF NEBRASKA
DEPARTMENT OF HEALTH
Bureau of Vital Statistics

57-006246

BIRTH NO. 126..... CERTIFICATE OF DEATH STATE FILE NO.....

1. PLACE OF DEATH a. COUNTY HARLAN L. 300		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE NEBRASKA b. COUNTY HARLAN	
b. CITY (If outside corporate limits, write Rural) OR TOWN ORLEANS		c. CITY (If outside corporate limits, write RURAL) OR TOWN ORLEANS	
c. LENGTH OF STAY 15 YRS		d. STREET ADDRESS (If rural, give location) - NONE	
d. FULL NAME OF (If not in hospital or institution, give street address) HOSPITAL OR INSTITUTION HOME			
3. NAME OF DECEASED (Type or Print) a. (First) EFFIE b. (Middle) MAV c. (Last) LLOYD			4. DATE OF DEATH (Month) (Day) (Year) 6 23 57
5. SEX F	6. COLOR or RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH (last birthday) 6/29/1887
9. AGE (In yrs. If Under 1 Yr. (If Under 24 Hrs. last birthday) Mos. Days Hours Min. 69		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) CLOTHING STORE	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) CLOTHING STORE		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
11. BIRTH- (City, town or county) (State) or foreign country) EDGAR, NEAR		12. CITIZEN OF WIL. COUNTRY? U.S.	
13. FATHER'S NAME FREDRICK WHEELAND		14. MOTHER'S MAIDEN NAME LAWRENCE, LLOYD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 507-47-4389	
17. INFORMANT'S NAME or Signature & Address Della Porter, Orleans Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* a) Retroperitoneal malignancy			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) 157X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY OR TOWN) (COUNTY) (STATE) (If rural area, write RURAL)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/25 , 19 57 , to 6/23 , 19 57 , that I last saw the deceased alive on 6/23 , 19 57 , and that death occurred at 12 m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. E. McGraw M.D.		23b. ADDRESS Orleans Mo	
23c. DATE SIG. 6/23/57			
24a. BURIAL or CREMATION REMOVAL <input type="checkbox"/> (Specify) 6/26/57 ORLEANS CEMETERY		24b. LOCATION (City, town, or county) ORLEANS NEAR	
DATE RECD BY LOCAL REG. 7-9-57		REGISTRAR'S SIGNATURE Schuman	
		25. GENERAL DIRECTOR'S SIGNATURE Ray C. Mitchell	

TO BE ACCOMPANIED WHEN BODY IS EXAMINED BY NEBRASKA STATE DEPARTMENT OF HEALTH. I personally embalmed the body of **Effie May Lloyd** deceased named herein.