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.

PLACE OF DEATH

County Callaway Co

Township Shamrock

or

Village

or

City (NO. St.: Ward)

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

Registration District No. 116 File No. 11837

Primary Registration District No. 5166 Registered No. 8

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

FULL NAME Lawrence A. Hill

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word): Single

DATE OF BIRTH: July (Month) 16 (Day), 1894 (Year)

AGE: 19 yrs. 9 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Callaway Co

PARENTS
NAME OF FATHER: Frank Hill
BIRTHPLACE OF FATHER (City or town, State or foreign country): Warrenton Co
MAIDEN NAME OF MOTHER: Sarah J. Barnes
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Montgomery Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy D. Barnes

(ADDRESS) Shamrock

Filed Apr 19, 1914 A. Hirsch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 15 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 15, 1914 to Apr 18, 1914, that I last saw him alive on Apr 18, 1914 and that death occurred, on the date stated above, at 2:00 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

107 h

(Duration) ___ yrs. ___ mos. 16 ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. 1 ds.

(Signed) W. C. Hudson M. D.

Apr 18, 1914 (Address) Montgomery City, Mo

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

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

PLACE OF BURIAL OR REMOVAL: High Point

DATE OF BURIAL: 4/19, 1914

UNDERTAKER: C W Hopkins #1487

ADDRESS: Montgomery City Mo

W-19-July 25

MISSOURI STATE BOARD OF HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Revised United States Standard Certificate

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

[If death occurre hospital or insti give its NAME i of street and numl

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 19

that I last saw h..... alive on ....., 19

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....

(Signed).....

....., 191..... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIEN RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL

UNDERTAKER	ADDRESS