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

Do not use this space.

18236

1. PLACE OF DEATH
County St. Francois — Registration District No. 773 — File No.
Township St. Francois — Primary Registration District No. 6018A — Registered No. 79
City Near Farmington (No. ..... St. ..... Ward)

2. FULL NAME George Bill
(a) Residence. No. State Hospital No.4 St., ... Ward. Commerce, Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 9 mos. 22 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

JIL 9

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ------ Ford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not known

7. AGE — YEARS: 55 — MONTHS: — DAYS: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Light Tender for U.S. Marine)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Scott Co
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Morgan Bill
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER -----Cinstang
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Scott Co
(STATE OR COUNTRY) Missouri

14. INFORMANT Hospital Records
(Address)

15. FILED 5-23-1928 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-21 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927, to 5-21, 1928 that I last saw him alive on 5-20, 1928, and that death occurred, on the date stated above, at 1:35 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypostatic Pneumonia 83
111B
186A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Fractured Hip & Parisis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical X Ray + Lab.
(Signed) P. S. Tate, M. D
, 19 (Address) Hosp. #4 Farmington Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cape Girardeau Mo
DATE OF BURIAL: 5-24 1928

20. UNDERTAKER: Walker Und. Co.
ADDRESS: Cape Girardeau 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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County St. Francois — Registration District No. 773 — File No.
Township — Primary Registration District No. 6018a — Registered No. 79
City (No. , St. Ward)

2. FULL NAME George Bill
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 7-19-28 B J Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-21, 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypostatic Pneumonia
Fracture of hip was due to falling on floor. Complicated by fractured leg & bedsores on fracture
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Fractured hip & bedsores
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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

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