

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

Do not use this space.

1. PLACE OF DEATH

County Jasper Registration District No. 407 File No. 24168
 Township Cartersville Primary Registration District No. 4241 Registered No. _____
 City Cartersville (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 219 N. Wilson 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 29 1927
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 8 18
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Child
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Cartersville (STATE OR COUNTRY) Missouri
 10. NAME OF FATHER Robert Hill
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 12. MAIDEN NAME OF MOTHER Hill, Bessie
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

14. INFORMANT Robert Hill (Address) Cartersville, Mo
 15. FILED 7/18 1928 W. H. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1928
 17. I HEREBY CERTIFY, That I attended deceased from July 7, 1928, to July 17, 1928 that I last saw her alive on July 17, 1928; and that death occurred, on the date stated above, at 7:15 A.M.

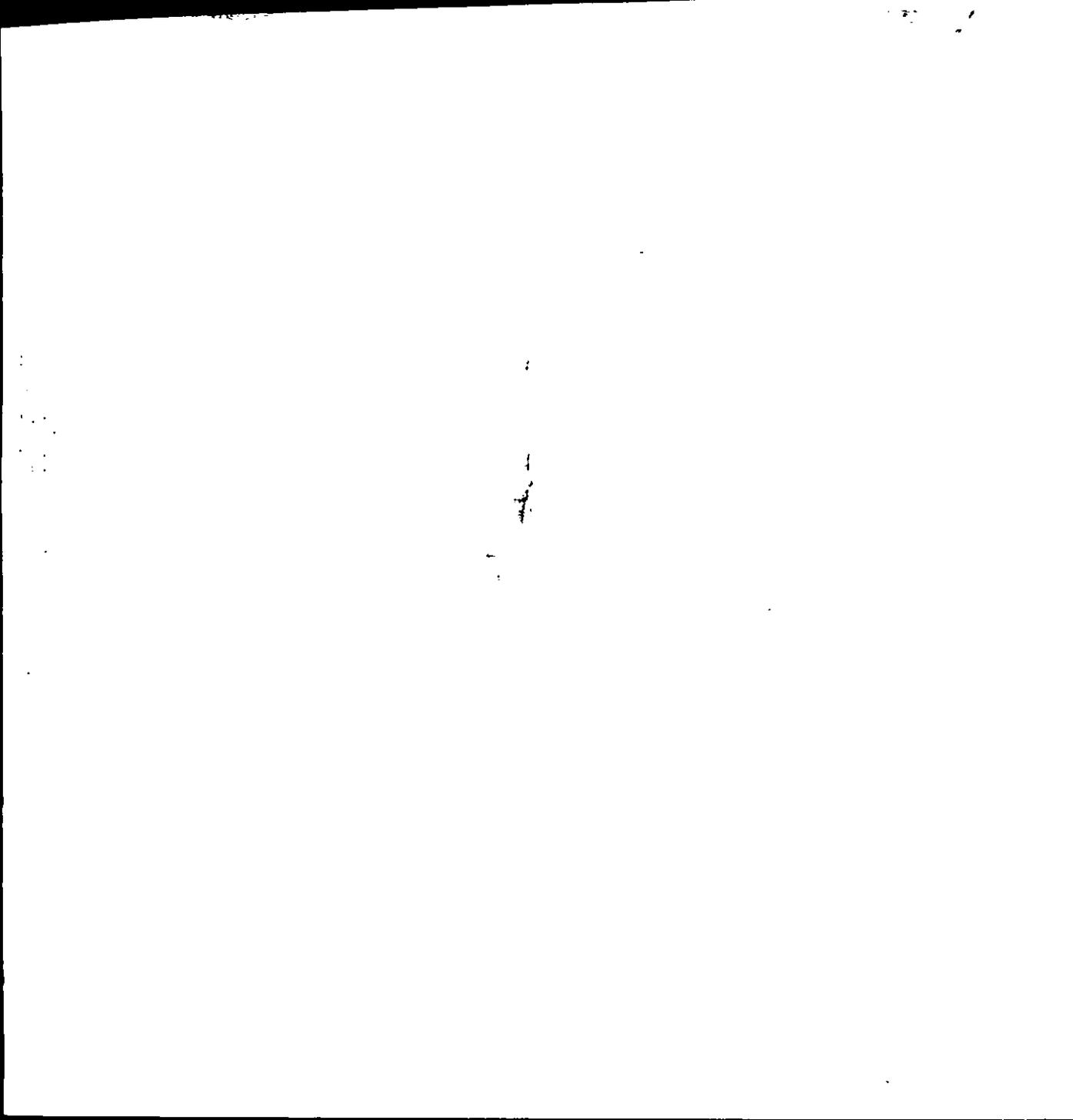
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Injury to head
18 1/2 (duration) yrs. mos. 30 da.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. _____
 19. DID AN OPERATION PRECEDE DEATH. _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS (Signed) M. S. Slaughter, M.D.
7-19-28 (Address) Meigs City, 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 Cartersville Cemetery DATE OF BURIAL 7/18 1928
 20. UNDERTAKER Meigs City Undertaking Co. Meigs City, Mo ADDRESS _____



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jasper Registration District No. 407 File No.
 Township Primary Registration District No. 424.1 Registered No.
 City Centerville (No.) St. Ward

2. FULL NAME

Mary Lou Hill

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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)

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 9-11-28 Ch May REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Injury to head according to history of care from parents - child fell from bed and symptoms developed
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) grew worse until death
 (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) W S Slough M. D.
 (Address) 19

*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

20. UNDERTAKER ADDRESS

REGISTRATION FEE SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE

SUPPLEMENTARY

S-24168