WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

33611

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No.

Township Kaw Primary Registration District No. 1002 Registered No. 4151

City Kansas City (No. 15th & Paseo St. Ward)

2. FULL NAME Garland Hill

(a) Residence. No. 1919 E. 9th St., 9 Ward. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Roxie Hill

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 23, 1892

7. AGE Years 36 Months 5 Days 16 If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Arkansas

PARENTS

10. NAME OF FATHER Charlie Hill

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Amanda Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Not Known

14. INFORMANT Mrs Roxie Hill

(Address) 1919 E. 9th St

15. FILED 10/12, 1928 M. M. Crane Ass REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 9 - 1928

17. Deputy Coroner

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:

Homicide - Firearms

173

1917

(duration) ......yrs. ......mos. ......ds.

CONTRIBUTORY (SECONDARY)

(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? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy

(Signed) [illegible], M. D

10/9/28, 19 (Address) Deputy Coroner

*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 West Lawn

DATE OF BURIAL Oct 14, 1928

20. UNDERTAKER Adkins Bros

ADDRESS 2000 E. 12th