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

Do not use this space. 1578

399

1. PLACE OF DEATH
County Jackson Registration District No. 1002 File No.
Township Kaw Primary Registration District No. Registered No.
City K. C. Mo. (No. Wesley Hospital St. Ward)

2. FULL NAME Madge Hill
(a) Residence. No. 621 Lewis St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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 Fe
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 James L. Hill
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch-19-1870
7. AGE Years 58 Months 9 Days 22 If LESS than 1 day, ...hrs. or ......min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Mo.

PARENTS
10. NAME OF FATHER J. H. Dunaway
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Mary Mason
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT Jas. L. Hill
(Address) 621 Lewis Ave
15. FILED 1-13, 1929 M. McEwen asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-11-1929
17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 11, 1929, that I last saw her alive on Jan 10, 1929, and that death occurred, on the date stated above, at 6 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS: General Periotonitis
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (SECONDARY) Intestinal Obstruction
(duration) yrs. mos. 7 ds.
18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Her Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Findings
(Signed) C. A. McGuire M.D.
1/12, 1929 (Address) 829 Rialto Bldg.

*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 Mt. Moriah
DATE OF BURIAL Jan. 14, 1929
20. UNDERTAKER Mrs. C. L. Foster
ADDRESS K. C. 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.
WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD

8426 Milton

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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..... Registration District No. 399 File No.....

Township..... Primary Registration District No. 1002 Registered No. 169

City K City (No....., St. ..... Ward)

2. FULL NAME Madge 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.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	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 1/13, 19 29 M. M. Brouner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11 1929

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:

General Peritonitis
following Ruptured
Appendix
(duration)..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction
(duration)..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed) C. A. Wilburn, M. D
, 19 (Address) 829 Rialto

*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

N. B. — 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.

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

S-1578