

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

Do not use this space.

11820  
11/2/29

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.

30 1929

1. PLACE OF DEATH *Petta*  
 County.....  
 Township.....  
 City.....*Sedalia* (No. *13th St*)  
 Registration District No. *668*  
 Primary Registration District No. *3032*  
 Registered No. *95* (St. .... Ward)  
 2. FULL NAME *William F 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 8-1929*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, *9* hrs. or *9* min.  
 8. OCCUPATION OF DECEASED *160*  
 (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

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 9 1929*  
 17. I HEREBY CERTIFY, That I attended deceased from *March 8, 1929*, to *March 9, 1929*, that I last saw him alive on *March 8, 1929*, and that death occurred, on the date stated above, at *2h*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Instability to establish respiration properly (duration) yrs. mos. 1/2 da.*

CONTRIBUTORY (SECONDARY) *160* (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) *Sedalia* (STATE OR COUNTRY) *Mo*  
 10. NAME OF FATHER *W H Hill*  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*  
 12. MAIDEN NAME OF MOTHER *Ethel Murphy*  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

18. WHERE WAS DISEASE CONTRACTED *160*  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
 WAS THERE AN AUTOPSY.....  
 WHAT TEST CONFIRMED DIAGNOSIS.....  
 (Signed) *Frank R. Mowley*, M. D.  
 , 19 (Address) *Sedalia*

\*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.

14. INFORMANT *W H Hill* (Address) *Sedalia Mo*  
 15. FILED *3-23-29* *J. J. Lovo* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Sedalia Mo* DATE OF BURIAL *Mar 10 1929*  
 20. UNDERTAKER *J. J. Lovo* ADDRESS *Sedalia*

