

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

Do not use this space.

13675

112

1. PLACE OF DEATH
 City Webster
 Township Manqua
 City Manqua No. 1

Registration District No. 900
 Primary Registration District No. 6217

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Mildred Maxine Hill
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 - 1929

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 - 1929 to Nov 23 - 1929 that I last saw her alive on Nov 23 - 1929, and that death occurred, on the date stated above, at 10:45 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 29 - 29

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 24

108 Pneumonia
 (duration) yrs. mos. da.

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

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

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

10. NAME OF FATHER Stanley Hill

8/6 DID AN OPERATION PRECEDE DEATH? DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER Theresa Lettner

WHAT TEST CONFIRMED DIAGNOSIS (Signed) H. T. Schlicht, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

(Address) Manqua 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.

14. INFORMANT (Address) Stanley Hill
Manqua Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Mothers Cemetery Nov 27 - 1929

15. Date May 8 1930 Registrar H. C. Williams

20. UNDERTAKER ADDRESS
Yes Bolton Manqua

WRITE PLAINLY, WITH UNFADING INK. 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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Webster Registration District No. 900 File No.
 Township Monroe Primary Registration District No. 6207 Registered No.
 City (No.) St. Ward)

2. FULL NAME Mildred Maxine Dill
 (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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u> (<i>give the word</i>)		
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)				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 25 1929

17. I HEREBY CERTIFY that I attended deceased from 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:
Pneumonia
Lobar
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 10/12
 (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
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

15. FILED May 9 29 D. C. Williams REGISTRAR

WHITE PAPER, WITH UNFADING INK--THIS IS A TYPEWRITER SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Y. 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.

