

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

Do not use this space.

868

1. PLACE OF DEATH

County Harrison
Township _____
City Bethany

Registration District No. 337
Primary Registration District No. 4197

File No. 540
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma N. Hillyard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/28/1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 5 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Virginia

10. NAME OF FATHER Isaac Hillyard

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

12. MAIDEN NAME OF MOTHER Lena Yocum

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

14. INFORMANT (Address) Chas. Hillyard Bethany

15. FILED 11/10/30 M. H. Starned REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/9 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 8th 1929, to Jan 9 1930 that I last saw h. m. ... alive on Jan 9 1930, and that death occurred, on the date stated above, at 8:15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular disease of heart
131

CONTRIBUTOR Indefinite (duration) yrs. mos. da. Chronic Indurational nephritis (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS:

(Signed) Dr. J. H. Reed M.D. , 19 (Address) Bethany 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

DATE OF BURIAL

Phillabam Cemetery 1-12 1930

20. UNDERTAKER

ADDRESS

S. M. Haas Bethany, 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.

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6
1
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