

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

Do not use this space.

1331

File No. 323
Registered No. 323
St. _____ Ward _____

1. PLACE OF DEATH

County Jackson Registration District No. 398

Township Law

City Kansas City (No. 571 Troost, near)

Registration District No. 398

Primary Registration District No. 1

2. FULL NAME

Clifford Polston Hill
(a) Residence No. 571 Troost, near St. 1 Ward 1

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? (if nonresident, give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unk 1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 36

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home
(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.

10. NAME OF FATHER Andrew Gibson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Sanford Hill
(Address) 571 Troost, near

15. FILED 1/23, 1930 M. M. Croome REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/20 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1929, to Jan 20, 1930 that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at 9:10 AM.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Mitral Stenosis
9000 (duration) yrs. 6 mos. ds.
CONTRIBUTORY (SECONDARY) asthma (duration) yrs. 10 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) M. M. Croome M. D.

1/23, 1930 (Address) 404 Maple
*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

Highland 1/23 1930
UNDERTAKER Patrick Byrne ADDRESS 1729 Lyden

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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Fred Corone,

