FEB 27 1934

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

Do not use this space.

10845-~~5~~ E

93

1. PLACE OF DEATH
County St. Clair — Registration District No. 766 — File No.
Township — Primary Registration District No. 4461-6011 — Registered No.
City (No. St. Ward)

2. FULL NAME Celia Ann Hillsman
(a) Residence, No. Oyer, St., Ward. Oyer, Mo.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. ~~SINGLE, MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (write the word) Widowed

5A. IF ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Albert Hillsman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unknown about 1858

7. AGE — YEARS 75 — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Early Copenhaver Oyer Mo

18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Pleasant Springs DATE 3-13 1933

19. UNDERTAKER (ADDRESS) F. B. Goodrich Roscoe, Mo

20. FILED 3-13 1933 Mr. F. B. Goodrich Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-12, 1933

22. I HEREBY CERTIFY, That I attended deceased from 5-10, 1932 to 3-6, 1933
I last saw her alive on 3-1, 1933 Death is said to have occurred on the date stated above, at 5:15 p.m.
The principal cause of death and related causes of importance were as follows:

Apoplexy

Date of onset: about 2 yrs. first stroke

Other contributory causes of importance: Unknown

Name of operation None Date of X
What test confirmed diagnosis? Paralysis Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury No, 19X
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. None
Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify No
(Signed) J. W. Richardson, M. D.
(Address) Tiffin 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.

CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible]

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

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 St Clair
Township Roseal
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 766
Primary Registration District No. 6011

File No. 10845 E
Registered No. .....

2. FULL NAME Celia Ann Hillsman

(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) W

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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

17. INFORMANT .....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19....

19. UNDERTAKER .....
(ADDRESS)

20. FILED ..... 19.... Mrs F. B. Goodrich
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/12, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Apoplexy	
Cerebral apoplexy	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
.....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) ....., M. D.
(Address) .....

SUPPLEMENTARY

10845-E