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

Do not use this space.

25809

14 2 7

1. PLACE OF DEATH

County Callaway — Registration District No. 104 — File No.

Township — Primary Registration District No. 3008 — Registered No. 143

City Fulton (No. , St. Ward)

2. FULL NAME Bessie Beatrice Hill

(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 3, 1907

7. AGE: YEARS 26 — MONTHS 1 — DAYS 28 — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Supervisor of girls
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: 55

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

FATHER

13. NAME: M. E. Hill
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER

15. MAIDEN NAME: Leona Powell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Viola Rogers, Fulton, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Hillcrest Cemetery DATE Aug. 2, 1933

19. UNDERTAKER (ADDRESS): Leo G. Wallace, Fulton, Mo.

20. FILED Aug. 2, 1933 R. N. Creus, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): August 1, 1933

22. I HEREBY CERTIFY, That I attended deceased from July 27th, 1933, to Aug. 1st. 1933, 19
I last saw her alive on Aug. 1st. 1933, 19 Death is said to have occurred on the date stated above, at 9:20 A.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Ileus Paralyticus, ~~follox~~ with cardiac insufficiency following shock, preceeded by appendectomy, ovarotomy.

Other contributory causes of importance: General debility, loss of wt. etc.

Name of operation: Appendectomy — Date of July 27
What test confirmed diagnosis? P. E. — Was there an autopsy? No

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? No
If so, specify
(Signed) Greene B. McCall, M. D.
(Address) Fulton Mo.

SEP 26 1933

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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.

25809

File No.

Registered No.

1. PLACE OF DEATH

County: Callaway — Registration District No.: 104

Township: — Primary Registration District No.: 3008

City: Fulton (No. , St. Ward)

2. FULL NAME: Bessie Beatrice Hill

(a) Residence, No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): S

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 R. N. Crews
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1 , 1933

22. I HEREBY CERTIFY, That I attended deceased from , 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

Illegal Paralytic
with Cardiac
insufficiency following
a septic pneumonia, complicated by
hypertonicity, vomiting

Other contributory causes of importance:

The above is all that I know concerning cause of death, and diagnosis. G. D. McCall

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

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

Blank statement of OCCUPATION is very important.

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