

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

Do not use this space.

42962

1. PLACE OF DEATH *8 1935*
 County *Jackson* Registration District No. *399*
 Township *Linn* Primary Registration District No. *1002*
 City *K. C. Mo.* (No. *5823 East 14th St.*) Registered No. *5823*
 St. *Mo.* Ward *14*

2. FULL NAME *Walter G. Hill*
 (a) Residence, No. *5823 - E - 14th St.* Ward. *14*
 (Usual place of abode) (If nonresident, give city or town and State)
 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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *No Record*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *No Record*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *70*
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Union Clothing*
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *1228 Grand*
 10. Date deceased last worked at this occupation (month and year) *No Record* 11. Total time (years) spent in this occupation *No Record*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec - 11 - 34*
 22. I HEREBY CERTIFY, That I attended deceased from *1934* to *1934*.
 I last saw him *at home* on *Dec 11*, 19*34*. Death is said to have occurred on the date stated above, at *8:30 am*.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia Date of onset *12/11/34*
 Other contributory causes of importance: *Rail Train Injuries*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record*
 13. NAME *No Record*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record*
 15. MAIDEN NAME *No Record*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record*
 17. INFORMANT *Rev. Bruffett* (ADDRESS) *Home City - Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Greenwood* DATE *12/13/34*
 19. UNDERTAKER *Mrs. C. L. Fowler* (ADDRESS) *918 Brooklynn Ave*
 20. FILED *12 34* M. M. *Carson* Registrar.

Name of operation *Autopsy* Date of *12/13/34*
 What test confirmed diagnosis? *Autopsy* Was there an autopsy? *Yes*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *No* Date of injury *No*
 Where did injury occur? *No* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. *No*
 Manner of injury *No*
 Nature of injury *No*
 24. Was disease or injury in any way related to occupation of deceased? *No*
 If so, specify *No*
 (Signed) *Russell M. Kerr*, M. D.
 (Address) *Deputy Coroner*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

