

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

Do not use this space.

33275

OCT 19 1937

**1. PLACE OF DEATH**

County Jackson Registration District No. 379 File No. \_\_\_\_\_  
 Township Jay Primary Registration District No. 1002 Registered No. \_\_\_\_\_  
 City Jays City (No. 103940-Jackson) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 3945 Jackson 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 M 4. COLOR OR RACE- Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alma Hilliard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 14 1900  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
37 1 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Ice Fuel

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) Graton Iowa

13. NAME Tom Hilliard

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va

15. MAIDEN NAME Dora Coffman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Alma Hilliard 3945 Jackson

18. BURIAL, CREMATION, OR REMOVAL PLACE Catholic Church DATE 9/14 1937

19. UNDERTAKER (ADDRESS) Mr. C. L. Foster 918 Broadway

20. FILED Sept 13 1937 M. M. Korove Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13 1937

22. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1937 to Sept 13, 1937. I last saw him alive on Sept 13, 1937. Death is said to have occurred on the day stated above, at 7:35 a.m.  
 The principal cause of death and related causes of importance were as follows:

Acute Myelogenous Leukemia

Date of onset 5/9/37

Other contributory causes of importance:  
Acute Suppurative Otitis  
Acute Otitis Media (chronic)

8/20/37  
8/9/37

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Leukogram 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) Joseph A. Foster M. D.  
 (Address) 446 North 11th St. Kansas City, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state

100 1307  
3102 Perry Ave.

**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..... Registration District No. 399  
 Township..... Primary Registration District No. 1002  
 City..... (No. 3940, Jackson) St. .... Ward)

File No.....  
 Registered No. 3720

**2. FULL NAME**

(a) Residence, No. .... St., .... Ward.

(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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Wh 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
37

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)

13. NAME

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

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 9/13/37 J. H. Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 13 1937

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

I last saw him ..... 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:

Leptemia Date of onset

Other contributory causes of importance:

Surg. Stomatitis  
As Periosteitis (Traumatic)

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 5/9 1937

Where did injury occur? Near Chebar Springs Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Automobile accident

Nature of injury Blow of st. leg

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Joseph A. Fogarty M. D.

(Address) 406 Northman Bldg. K. C. Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-33275