

DEC 14 1937

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

40571

Do not use this space.

1. PLACE OF DEATH

(a) County Barry Registration District No. 29
(b) Township Crane Creek Primary Registration District No. 5046 Registered No. 63
(c) City Crane (d) Street No. R.F.D. # 1 St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Cora Angeline Hilton

(a) Residence, No. Crane Mo. R.F.D. # 1 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hiram Hilton

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 2-1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 66 7 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as 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) Missouri13. NAME Wm Allman14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Susan Thomas16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri17. INFORMANT (ADDRESS) Finis R Hilton, Okla City Okla.18. BURIAL, CREMATION, OR REMOVAL PLACE Leann Mo. DATE Nov. 26 193719. FUNERAL DIRECTOR (ADDRESS) King Funeral Home, Aurora, Mo.20. FILED 12-1 1937 Geo Neuman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 26 193722. I HEREBY CERTIFY, That I attended deceased from 9-30, 1937, to 11-26, 1937.I last saw her alive on 11-26, 1937. Death is said to have occurred on the date stated above, at 5.40 A.M.

The principal cause of death and related causes of importance were as follows:

Malignancy of Gall bladder & pylorus and of stomach Date of onset _____

Other contributory causes of importance:

Large Ventral Hernia & Chronic Intestinal trouble

Name of operation None Date of _____
What test confirmed diagnosis? Physician Was there an autopsy? No23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury _____

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 None
Nature of injury _____24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____(Signed) Geo Neuman M. D.
(Address) Aurora Mo.

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STATEMENT BY LICENSED EMBALMER

I, Licensed Embalmer No.
hereby certify that the body recorded on the reverse side of this certificate was embalmed by *Pat Embalmer*
..... L. E.
No. or by Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Barry Registration District No. 29
(b) Township Crane Creek Primary Registration District No. 3046
(c) City _____ (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Cora Angelina Hilton

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 26 1937

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

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.

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

The principal cause of death and related causes of importance were as follows:
Malignancy of gall bladder & uterus and of stomach. Diagnosis made by history obtained from exam. Malignancy started in gall bladder.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
66 7 24

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

Other contributory causes of importance:
by extensive involution of pyloric end of stomach.

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

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) King Funeral Home Aurora, Mo

20. FILED 11-28 1937 Dr. Geo W. Henneman Local Registrar.

Name of operation W. E. Gottren
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? NO

If so, specify _____
(Signed) W. E. Gottren, M. D.
(Address) Aurora Mo

SUPPLEMENT

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.

