

OCT 19 1938

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

31847  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104  
(b) Township Fulton Primary Registration District No. 3008 Registered No. 232  
(c) City Fulton (d) Street No. Cancer Hosp 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

William Hill U. S.  
(a) Residence, No. Osceola Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-6-30  
7. AGE YEARS 75 MONTHS 9 DAYS 18 If LESS than 1 day, .hrs. or .min.  
8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc. Don't know  
9. Industry or business in which work was done, as saw mill, bank, etc. Retired merchant  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 22, 1938  
22. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1938, to Sept 25, 1938  
I last saw him alive on Sept 25, 1938 Death is said to have occurred on the date stated above, at 6:10 p.m.  
The principal cause of death and related causes of importance were as follows:

Chronic myocarditis Date of onset Don't know

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know Texas

FATHER 13. NAME Wm. G. Hill Don't know  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Martha Chestnut Don't know  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

17. INFORMANT (ADDRESS) Mrs. Sam Logan  
Reformer Cancer Hospital  
Fulton Mo. Osceola Mo.

18. BURIAL, CREMATION; OR REMOVAL PLACE Quincy Mo. DATE 9-26-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ed Shultz  
Osceola Mo.

20. FILED Sept 26 1938 R. N. Crews  
Local Registrar.

Other contributory causes of importance:  
Carcinoma of skin of forehead  
and of eye  
Cellulitis of P. Neg.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) D. S. Spaff, M. D.  
(Address) Fulton Mo.

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

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Callaway Registration District No. 104  
 (b) Township..... Primary Registration District No. 3008 Registered No.....  
 (c) City Fulton (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 William Hill

(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

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

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.  
25 8 18

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

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 25, 1938

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:

Chf. Myo - Carditis Date of onset  
Primary skin of forehead  
skin of 527  
Carcinoma of forehead  
and left eye of cellulitis of  
Rt leg

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) W S Lapp, M. D.

(Address) Fulton Mo

SUPPLEMENTARY

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

