DEC'D FEB 27 1939

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

3976
Do not use this space.

1. PLACE OF DEATH
(a) County Saline
(b) Township
(c) City Marshall, Mo.
Registration District No. 796
Primary Registration District No. 3038 Registered No. 8
(d) Street No. Fitzgibbons Hospital 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 Miss. Lula May Hill
(a) Residence, No. Arrow Rock, Missouri 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: Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 10, 1896
7. AGE: 42 YEARS; MONTHS: 2; DAYS: 27; If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
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) Arrow Rock, Missouri 0

FATHER
13. NAME Chas. H. Hill 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arrow Rock, Mo. 0

MOTHER
15. MAIDEN NAME Rebecca Brown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arrow Rock, Mo.

17. INFORMANT (ADDRESS) Mr. Chas. H. Hill R.F.D. # 3 Boonville, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Old Sappington DATE Jan. 8, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. J. Meister Boonville Missouri
20. FILED 1-7-1938 Mary Kent Dep. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1939, to Jan 6, 1939
I last saw her alive on Jan 6, 1939 Death is said to have occurred on the date stated above, at 8 P. m.
The principal cause of death and related causes of importance were as follows:
General peritonitis — Date of onset Jan 3
Other contributory causes of importance: Fibroid uterus twisted pedicle - Hysterectomy
Name of operation Hysterectomy Date of Jan 3
What test confirmed diagnosis? Clinical 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) [signature] M. D.
(Address) Marshall, Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very in

54 B

RECEIVED
District Health Officer No. 2
District File Number
Date Filed 1/9/39

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, E. Benjamin Cart, or by _____, Registered Apprentice No. 4059, working under my personal supervision.

Signed E. Benjamin Cart

Licensed Embalmer No. 4059

P. O. Address 415 4th St.

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.)

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 Saline — Registration District No. 796
(b) Township Mars — Primary Registration District No. 3038 — Registered No. 8
(c) City Marshall — (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 Miss Lula May Hill
(a) Residence, No. ..... 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: 7
4. COLOR OR RACE: Col
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: 42 — MONTHS: 2 — DAYS: 27 — If LESS than 1 day, ... hrs. or ..... min.

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) 1 - 6, 1939

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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:

General peritonitis — Date of onset

54 P.

Other contributory causes of importance:
Fibroid uterus twisted pericle - Hysterectomy

Name of operation Hysterectomy 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 Malignancy
Nature of injury R. Haynes

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Robert C. Haynes, M. D.
(Address) Marshall Mo

SUPPLEMENTARY

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.

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