

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 5 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6108
State File No. 4
Registrar's No. 4

Registration District No. 98 Primary Registration District No. 4060

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Kingston
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME Eva Jane Hill 404
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Williams Hill
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased July 31 1898 (Month) (Day) (Year)

8. AGE: Years 61- Months 6 Days -20 If less than one day hr. min.

9. Birthplace Kingston Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name James Grigoby
13. Birthplace Bryant Ind. (City, town, or county) (State or foreign country)

14. Maiden name Frances Ann Pearson
15. Birthplace Bryant Ind. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Pauline Switzer
(b) Address Kingston Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Kingston Cemetery

18. (a) Signature of funeral director Ormer Clark
(b) Address Kingston Missouri 102

19. (a) At 22-1940 (Data received local registrar) (b) Mrs Ruth Hill (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 21 year 1940 hour 3:00 minute A M.

21. I hereby certify that I attended the deceased from Nat at all, 19, to, 19; that I last saw h. alive on, 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Acute dilatation of heart, Mitral regurgitation.
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

28. Signature M. J. Daly (Coroner) (M. D. or other)
Address Hamiston Mo. Date signed 2/21/40

RECEIVED

District Health Officer No. 11,

District File Number 340-214

Date Filed MAR 4 1940

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.....

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

Signed Cramer Clark.....

Licensed Embalmer No. 3257

P. O. Address Kingston M.

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.

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Registration District No. 98

Primary Registration District No. 4060

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1. PLACE OF DEATH:

(a) County Caldwell
(b) City or town Kingston
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME

Eva Jane Hill

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7

5. Color or race w

6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife William Hill

6. (c) Age of husband, or wife, if died year ago years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

61

6

20

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

(19. (a) Feb 22-1940
(Date received local registrar)

(b) Mrs. Ruth Hill
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell

(c) City or town Kingston
(If outside city or town limits write "RURAL")

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that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature L. M. Daley (M. D. or other) _____

Address Hamilton Date signed _____

SUPPLEMENTARY

