

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15979**
Registrar's No. **101**

Registration District No. **773**

Primary Registration District No. **6018A**

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr. 3 mos. 13 ds
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Frank Hill **480**
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Iydia Rector 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 4-1 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 0 27 hr. min.

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

10. Usual occupation Miner

11. Industry or business _____

MOTHER FATHER
12. Name Benjamin F. Hill
18. Birthplace Washington Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Blanton
15. Birthplace Sullivan Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records of State Hospt. #1
(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-30-40
(Month) (Day) (Year)
(c) Place: burial or cremation Cemetery of State Hospt. #1

18. (a) Signature of funeral director Hugo Cozean
(b) Address Farmington, Mo.

19. (a) April 29-1940 (Date received local registrar) (b) T. J. Robinson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Washington
(c) City or town Potosi
(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 4 day 28
year 1940 hour Between 4 and 10 P. M.

21. I hereby certify that I attended the deceased from 3-8, 19 39, to 4-28, 19 40
that I last saw him alive on 4-28, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death: Strangulation, acute (hanging)
Due to (suicide)
Due to _____

Other conditions: Epileptic psychosis
(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) suicide
(b) Date of occurrence 4-28-40
(c) Where did injury occur? Farmington, St. Francois Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hospital No. 4
(Specify type of place)
While at work (e) Means of injury hanging

23. Signature Paul Schrader (M. D. or other) MD
Address Farmington, Mo Date signed 5-1-40

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.

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..... Not embalmed.....

Licensed Embalmer No.....

P. O. Address.....

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.