

Registration District No. 159 114 Primary Registration District No. 5867

1. PLACE OF DEATH:
(a) County Permiacot Mo
(b) City or town near Swift
(If outside city or town limits, write "RURAL" and name of township)
(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)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME B. H. Hillard 463
3. (b) If veteran, n-m-o name war _____ 3. (c) Social Security No. _____
4. Sex M 5. Color or race col.
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7-8-1894
(Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 10 If less than one day hr. min.

9. Birthplace Charbisdale Miss
(City, town, or county) (State or foreign country)
10. Usual occupation Carpenter
11. Industry or business _____
12. Name Shad Hillard
13. Birthplace Jackson Miss
(City, town, or county) (State or foreign country)
14. Maiden name Aggada Jones
15. Birthplace Ripley Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. H. Hillard
(b) Address Swift Mo
17. (a) (Burial, cremation, or removal) _____ (b) Date thereof May 19, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation Swift Mo
18. (a) Signature of funeral director Somel + Hill
(b) Address Hayti, Mo
19. (a) May 19, 1940 (b) Mary W. Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town Swift - Rural
(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 5 day 15
year 1940 hour 10 minute _____ M.
21. I hereby certify that I attended the deceased from 3-15-1940 to 5-18-1940
that I last saw him alive on 5-15-1940 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary heart disease
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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? _____
5 While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature A. G. Shurey (M. D. or other)
Address Hayti Mo Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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 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.....

J. Hill

Licensed Embalmer No. *2627*

P. O. Address *Lilbourn Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. ¹⁵⁶⁸² 22482

Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 114

Primary Registration District No. 5867

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

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(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 0

In this community _____ (Specify whether years, months or days)

3. (a) PRINTED FULL NAME B. A. M. O.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race col

6. (a) Single, widowed, married, divorced single
6. (c) Age of husband, or wife if alive _____ years

6. (b) Name of husband or wife _____

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____

(b) Address _____

19. (a) May 19, 1945 (b) Mary W. Cook

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (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 5 day 15 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 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 _____

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 A. G. Shere (M. D. or other)

Address Harzti Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

