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FILED JAN 8 1941

Registration District No. 467

Primary Registration District No. 4280

Registrar's No. 77

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
142 West Springfield St
(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 _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence
(c) City or town Aurora
(If outside city or town limits, write "RURAL")
(d) Street No. 142 West Springfield St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 29
year 1940 hour 7 minute 00 A. M.

21. I hereby certify that I attended the deceased from Dec 18, 1940, to Dec 28, 1940
that I last saw her alive on Dec 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of hip - shock following accident

Duration 10 days

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 9 months of death)

Major findings: Sexuality
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Sarah Elizabeth Hill

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, divorced Widowed

6. (b) Name of husband or wife John Hill 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 12 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name ? Henson

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known
(City, town, or county) (State or foreign country)

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dave Childers
(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof 12/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Aurora Mo.

18. (a) Signature of funeral director J.P. King
(b) Address Aurora Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Fall & broke hip
(b) Date of occurrence Dec 18 - 40
(c) Where did injury occur? At home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature J. Hill (M. D. or other) _____
Address 1211 Pleasant Date signed 12/31/40

RECEIVED

District Health Officer No. 6,

District File Number 141-2065

Date Filed JAN 2 1941

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

Herma L. Luridge

Licensed Embalmer No. 3072

P. O. Address Aurora 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43030

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 467

Primary Registration District No. 4280

Registrar's No. 77

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

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(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 _____
years, months or days)

3. (a) PRINT FULL NAME

Sarah Elizabeth Hill

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 60 Months 5 Days 17 If less than one day _____ 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 _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-1-41 (b) R. D. Cowan M.D.
(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 Dec day 29 year 1940 hour _____ minute _____ M.

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

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 J. Will Smith (M. D. or other) _____

Address Aurora Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-43030