V.S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43512

Registration District No. 678 Primary Registration District No. 5904 Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps

(b) ~~City or town~~ St James Mo

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Soldiers Home

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

(d) Length of stay: In hospital or institution 5 years (Specify whether

In this community 3 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Phelps

(c) City or town St James MO (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.

3. (a) PRINT FULL NAME SAMUEL T. HILLIARD

3. (b) If veteran, name war Span-Amer

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Edna Hilliard

6. (c) Age of husband or wife if alive years

7. Birth date of deceased January (Month) 31 (Day) 1873 (Year)

8. AGE:	Years	Months	Days	If less than one day
	67	10	28	hr. min.

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

10. Usual occupation Member of Home

11. Industry or business

FATHER
12. Name Bert HILLIARD
13. Birthplace DONT KNOW (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name DONT KNOW
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant C. H. Bullock

(b) Address St James Mo

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

(c) Place: burial or cremation Soldiers Home Cem.

18. (a) Signature of funeral director W.E. Rickleiter

(b) Address St James Mo

19. (a) 1/2/41 (Date received local registrar) (b) Elsie B Houx (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 29 year 40 hour 9 ck minute M.

21. I hereby certify that I attended the deceased from July 14, 1940, to Dec 29, 1940; that I last saw him alive on Dec 28, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. H. Fulbright (M. D. or other)

Address St James Mo Date signed 12 31 40

(Licensed Embalmer's Statement on Reverse Side)

APR 28 1947

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 me, Registered Apprentice No. ....., working under my personal supervision.

Signed Orcil E Licklich

Licensed Embalmer No. 3566

P. O. Address St Jenny 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.