

FILED DEC 11 1942

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 310

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirkville
(c) Name of hospital or institution:
Community Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirkville
(If outside city or town limits, write "RURAL.")
(d) Street No. 1002 N. Elson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Daniel D. Hilt

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Elizabeth Hilt 6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased Nov. 7 1858
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 19 If less than one day hr. min.

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

10. Usual occupation Transfer Line

11. Industry or business _____

MOTHER FATHER { 12. Name John Hilt
13. Birthplace Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Sally Ann Sloan
15. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Hilt
(b) Address Kirkville, Mo.
17. (a) Burial (b) Date thereof 11-20-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Refuge Cemetery

18. (a) Signature of funeral director D. P. Riley
(b) Address Kirkville Mo.
19. (a) 11/30/42 (b) Ms. J. L. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26
year 1942 hour 1:15 minute P. M.

21. I hereby certify that I attended the deceased from 11/24/42
1942 to 11/26/42 1942
that I last saw him alive on 11/26/42 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure
Due to Uremic Poisoning
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 2
23. Signature Esther P. Bann (M.-D. or other) D.O.
Address Kirkville, Mo. Date signed 11/26/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10/19

RECEIVED

District Health Officer No. 10

District File Number 12-42-4057

Date Filed Dec. 10-1942

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 D. E. Riley

Licensed Embalmer No. 4181

P. O. Address Herkville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

NO. 2B
5-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36505

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 310

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Community Housing Home
(If not in hospital or institution, write street number, or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether

In this community life
years, months or days)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Daniel D. Hill

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

4. Sex <u>m</u>	5. Color or race <u>w</u>	6. (a) Single, widowed, married, divorced. <u>w</u>
6. (b) Name of husband or wife.....		6. (c) Age of husband or wife if alive <u>7</u> years (Month) (Day) (Year)
7. Birth date of deceased <u>Nov 7</u> <small>(Month) (Day) (Year)</small>		

8. AGE: Years 84 Months 0 Days 0
If less than one day

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 26 year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him/her alive on..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: MYOCARDIAL INFARCTION

Due to anemic poisoning

Due to chronic nephritis

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

1312

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) (e) Means of injury

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-36505 1942