

WRITE PLAINLY, WITH UNFADING INK. THIS IS 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.

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FILED MAY 15 1946

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

13923
Do not use this space.

1. PLACE OF DEATH
 (a) County Camden Registration District No. 50
 (b) Township Orange Primary Registration District No. 5176 Registered No. 17
 (c) City Near Stouland Mo (d) Street No. 1 St. 15
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Washington Hillhouse
 (a) Residence, No. Near Stouland Mo St. (If nonresident, give city or town and State) 1
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Cara Hillhouse</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 27 1973</u>				
7. AGE	YEARS <u>69</u>	MONTHS <u>7</u>	DAYS <u>8</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>on his farm</u>			
	10. Date deceased last worked at this occupation (month and year) <u>2 yrs ago</u>		11. Total time (years) spent in this occupation. <u>all his life</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Stouland Mo</u>				
FATHER	13. NAME <u>Thomas Hillhouse</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Near Stouland Mo</u>			
MOTHER	15. MAIDEN NAME <u>Sarah Cunningham</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Laclede Co Mo</u>			
17. INFORMANT <u>Adrain Hillhouse</u> (ADDRESS) <u>Stouland Mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Hillhouse cemetery</u> DATE <u>Feb 6 - 1943</u>				
19. FUNERAL DIRECTOR (ADDRESS) <u>Stouland Mo</u>				
20. FILED <u>May 6 1943</u> <u>Erica Nelson</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Feb 6th 1943</u>	
22. I HEREBY CERTIFY, That I attended deceased from <u>Nov 15 1942</u> to <u>Feb 6 1943</u> I last saw him alive on <u>Feb 4 1943</u> Death is said to have occurred on the date stated above, at <u>10 a. m.</u> The principal cause of death and related causes of importance were as follows: <u>Hypertensive Heart Disease resulting in cerebral nephrosis</u>	
Other contributory causes of importance: <u>1310</u>	
Name of operation	Date of
What test confirmed diagnosis? <u>bed side test</u>	Was there an autopsy? <u>no</u>
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19..... Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury	
Nature of injury	
24. Was disease or injury in any way related to occupation of deceased? <u>no</u> If so, specify	
(Signed) <u>A. E. Carter</u>	M. D.
(Address) <u>Stouland Mo</u>	

RECEIVED

District Health Officer No. 7,
District File Number 4-43-445
Date Filed 5-13-43

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....
..... L. E.
No..... or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13923
Registrar's No. 17

Registration District No. 50

Primary Registration District No. 5-176

1. PLACE OF DEATH:

(a) County Cameron

(b) City or town Rural
(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) (Specify whether
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 George W. Hellhouse

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased June 27-1891
(Month) 11 (Day) (Year)

8. AGE: Years 69 Months 7 Days 14 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) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Virgil Evans (b) Address.....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I last saw him..... 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)

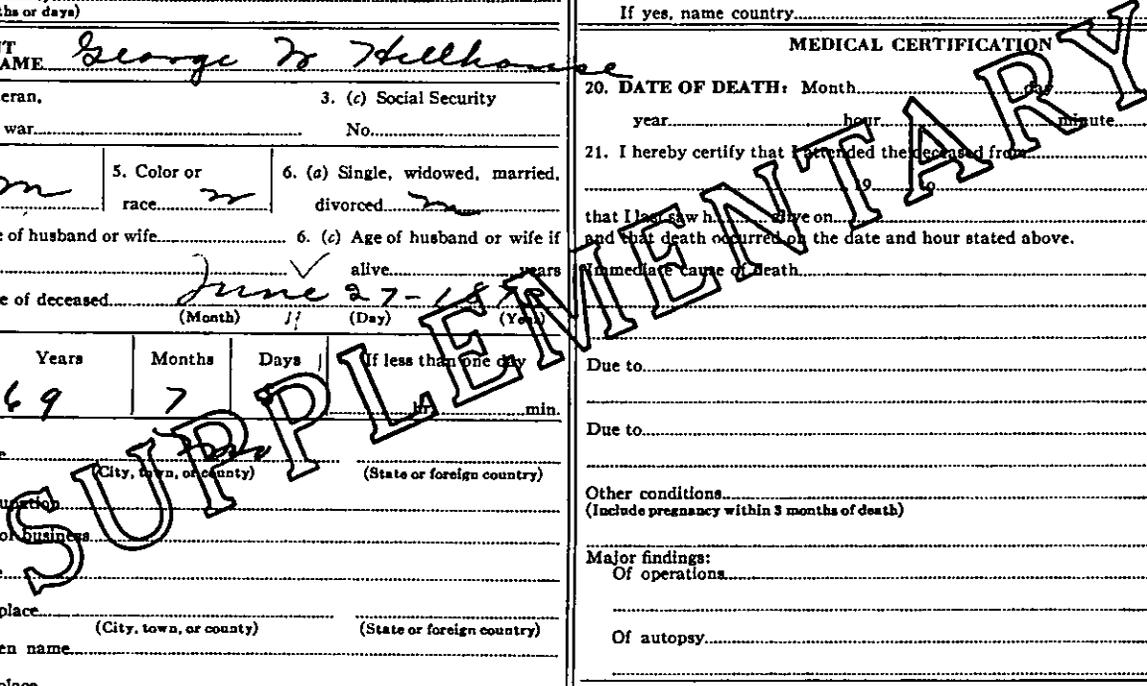
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

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

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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



Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

