

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8274

State File No. 0

Registrar's No. 482

FILED MAR 8 1944

Registration District No. 7

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County Hazh St. Louis
(b) City or town Mo.
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 94 days (Specify whether)
In this community 94 days years, months or days

3. (a) PRINT
FULL NAME

HENRY REGGON Hill
3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive 24 years (Month) (Day) (Year)

7. Birth date of deceased Nov 24 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 39 2 23 hr. min.

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

10. Usual occupation Fieldh.

11. Industry or business

12. Name William Allen Hill

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

14. Maiden name Martha Walls

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

16. (a) Informant Miss Ruth Lopez

(b) Address 2371 9th St. S.W.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-25-44 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Challen & Kelly

(b) Address 4386 Pine St.

19. (a) FEB 25 1944 (Date received local registrar) (b) E. G. Mc Gowan, M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 221 S Broadway (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16 year 1944 hour 2 minute 10 PM M.

21. I hereby certify that I attended the deceased from Nov 12 1943 to Feb 16 1944
that I last saw him alive on Feb 15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Pneumonia - for 11 mo?

Due to 1361

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 Robert Koch Hospital (M.D. or other)

Address Robert Koch Hospital Date signed 2/16/44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.