No. 2
1-4-41
-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

14688

State File No.

FILED MAY 10 1944

Registration District No. 428

Primary Registration District No. 5465

Registrar's No. 349

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

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Rural, N. Campbell Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Pearl Rest Home Route #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution One Month (Specify whether
In this community 45 yr.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 29

(c) City or town Rural, N. Campbell Twp. Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. Pearl Nursing Home, Route #4
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mary Dora Hill

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Unk.

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

7. Birth date of deceased July (Month) 16, (Day) 1864 (Year)

8. AGE: Years 79 Months 90 Days 3 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name Thomas Vanfosen
13. Birthplace Unknown (City, town, or county) Michigan (State or foreign country)

MOTHER
14. Maiden name Mary Giesler
15. Birthplace Unknown (City, town, or county) Mo (State or foreign country)

16. (a) Informant Comodore Shelley
(b) Address Como Hotel

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April (Month) -20 (Day) 44 (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Fred C. Thieme
(b) Address Springfield Mo

19. (a) 4-20-44 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1944 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased ~~from~~ on 3-18-44 and on 4-10, 1944, to 19 ; that I last saw her alive on April 10, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Pneumonia	4.5 da
Due to Fracture, right hip	6 wks.
Due to Mental deterioration, senile.	Unk.
Other conditions Senility (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186a
Of autopsy 10

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) Accident
(b) Date of occurrence About Mar 6, 1944
(c) Where did injury occur Springfield (City or town) Greene (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (e) Means of injury Fell

23. Signature James E. Amos (M. D. or other) M.D.
Address Springfield Mo Date signed 4-19-44

487

(Licensed Embalmer's Statement on Reverse Side)

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. Fred C. Lane

Licensed Embalmer No. 2099

P. O. Address 1100 Boonville

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

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

S. No. 2B
M—5-43
D I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. may

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 349

1. PLACE OF DEATH:
(a) County Green
(b) City or town Rural N. Campbell Twp
(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 years, months or days)
In this community

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 May Dore 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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 16 1864 (Month) (Day) (Year)
8. AGE: Years 79 Months 9 Days 3 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo. (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)
MOTHER
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
(b) Address
19. (a) 4-20-44 (Date received local registrar) (b) Dr W Hand (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 19 year 1944 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

14688