

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21302  
Registrar's No. 164

FILED JUN 20 1944

Registration District No. 42

Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lucy Lee Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution About 1 wk.  
In this community Broseley Community About 25 yrs.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Samuel Lewis Hill

3. (b) If veteran, name war - 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 Elmore Hill 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased June 25 1871  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 11 13 hr. min.

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

10. Usual occupation FARMING

11. Industry or business

MOTHER FATHER {  
12. Name Wm Hill  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)  
14. Maiden name AK  
15. Birthplace AK (City, town, or county) (State or foreign country)

16. (a) Informant Heber Hill

(b) Address Broseley Mo.

17. (a) Facial (Burial, cremation, or removal) (b) Date thereof May 9 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation Home Hill

18. (a) Signature of funeral director L. J. Campbell  
(b) Address Capbell, Mo.

19. (a) 5-15-44 (Date received local registrar) (b) Belle Spinnel (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler 12  
(c) City or town Broseley Mo. Rural 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th.  
year 1944 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from May 1 - 1944 to May 8 1944  
that I last saw him alive on May 8 - 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia  
Due to Acute nephritis 10 da  
Due to Broncho pneumonia 10 da

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. PHYSICIAN

Of autopsy. Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION

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?

23. Signature R. J. Campbell (M. D. or other) 0  
Address Poplar Bluff Mo. Date signed 5/15/44

RECEIVED

District Health Office No.

District File Number 644-2

Date Filed 6-8-44

**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.

FILED JUL 19

Registration District No. 43

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Butler  
 (b) City or town Caplan bluff  
(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

3. (a) PRINT FULL NAME Samuel L. Helf  
 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 m  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: June 25  
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days \_\_\_\_\_  
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) \_\_\_\_\_ (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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death thromb

Duration

Due to acute nephritis

Due to chronic pneumonia  
chronic nephritis 1 yr.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED  
 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?  
 While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

23. Signature Samuel Helf (M.D. or other) \_\_\_\_\_  
 Address Caplan Bluff Mo Date signed 6/24/44

SUPPLEMENTARY

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

2022