V. S. No. 2
00M—8-43
Rev. 5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 26 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

23083

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6338

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 31 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Morgan

(c) City or town Jacksonville
(If outside city or town limits, write "RURAL") R

(d) Street No.
(If rural, give location)

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

3. (a) PRINT FULL NAME Dr. Edward Lathrop Hill

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mildred Hill

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased October (Month) 20, (Day) 1905 (Year)

8. AGE: Years 38 Months Days 25 If less than one day hr. min.

9. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Doctor

11. Industry or business

FATHER
12. Name E.L. Hill
13. Birthplace Chester, (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Estelle Beckett
15. Birthplace Cutler, (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mildred Hill
(b) Address Jacksonville, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-16-44 (Month) (Day) (Year)
(c) Place: burial or cremation DuQuoin, Illinois

18. (a) Signature of funeral director Albert H. Hoppe Inc.
(b) Address 4700 Washington Blvd.

19. (a) JUL 18 1944 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15th year 1944 hour 5 minute 00 A.M.

21. I hereby certify that I attended the deceased from June 15th 1944 to July 15th 1944; that I last saw him alive on July 15th 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Myelogenous leukemia	6 years
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? Means of injury

23. Signature F R Bradley (M. D. or other)
Address BARNES HOSPITAL Date signed

(Licensed Embalmer's Statement on Reverse Side)

6338

6338

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 John Ogonoski

Licensed Embalmer No. 3398

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.