No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14080

Registration District No. 23 Primary Registration District No. 5825 Registrar's No. 4356

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Rural Mo
(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 entire life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County New Madrid
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Melton 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 Lillian Hill
6. (c) Age of husband or wife if alive 25 years
7. Birth date of deceased Oct (Month) 7 (Day) 1904 (Year)

8. AGE: Years 30 Months 5 Days 6 If less than one day — hr. — min.

9. Birthplace New Madrid County (City, town, or county) Mo (State or foreign country)
10. Usual occupation farming
11. Industry or business
MOTHER FATHER
12. Name Clarence Hill
13. Birthplace (City, town, or county) Missouri (State or foreign country)
14. Maiden name Mary Willis
15. Birthplace (City, town, or county) Ky (State or foreign country)
16. (a) Informant Roy Hill
(b) Address Risco Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-15-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mounds cemetery
18. (a) Signature of funeral director Thomas C Knight
(b) Address Parma
19. (a) Apr 4/45 (Date received local registrar) (b) Mrs B B Rademaker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13 year 1945 hour 2 minute 30 P.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: Crushed head, Cerebral body	
Due to: Kicked by horse	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 0	
Of autopsy:	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 March 13-1945
(c) Where did injury occur? New Madrid (City or town) Mo (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 Leo Hedgpeth Coroner (M. D. or other)
Address New Madrid Date signed 3/21-45

1028 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 445-42
Date Filed 4/7/45

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 Thomas E Knight

Licensed Embalmer No. 2189

P. O. Address Perma Mo

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

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

No. 2B
-3-45
43880

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

Sept

State File No.

Registration District No. 239 Primary Registration District No. 6225 Registrar's No. 4356

1. PLACE OF DEATH:

(a) County New Madrid

(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Rural
(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 Mellon Hill

3. (b) If veteran, name war ✓

3. (c) Social Security No. —

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 7 — 1898
(Month) (Day) (Year)

8. AGE: Years 30 Months 6 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month Jan Day 13 year 1945 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.

Immediate cause of death — Duration

Crushed head
Cut body

Due to
Runover (?) by train

Due to
Train hit auto

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

14080