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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37210

State File No.

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 899A

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. John's Hospital
(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 Missouri (b) County Dallas
(c) City or town Buffalo Rural (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FREIDA PAULINE 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 Infant
6. (b) Name of husband or wife NONE
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased June (Month) 24 (Day) 1945 (Year)

8. AGE: Years 0 Months 4 Days 28 If less than one day hr. min.

9. Birthplace Dallas Co (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Infant
11. Industry or business

MOTHER FATHER
12. Name W. E. Hill
13. Birthplace Dallas Co (City, town, or county) Mo 0 (State or foreign country)
14. Maiden name Selma Clark
15. Birthplace Dallas Co (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant W E Hill
(b) Address Buffalo Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 11-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Pleasant
18. (a) Signature of funeral director R B Jones
(b) Address Buffalo Mo
19. (a) 11-28-45 (Date received local registrar) (b) W. L. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1945 hour 11 minute 15P M.
21. I hereby certify that I attended the deceased from Nov 2-1945, 19 to Nov 2-1945, 19; that I last saw her alive on Nov 2-1945, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intussception of Intestine	
Due to at Ileocecal Valve	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Same as above
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:
(c) 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 A. D. Blair (M. D. or other)
Address Springfield Mo Date signed 11/28/45

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(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 Maria B. Jones

Licensed Embalmer No. 4332

P. O. Address Buffalo, Mo.

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.