S. No. 2
—12-45
5-17-39
I X47070

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

FILED NOV 7 1946

State File No. 32553

Registration District No. _____ Primary Registration District No. 3000 Registrar's No. ~~393~~ 393

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Kirksville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Grim Smith Hospital O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 hours (Specify whether years, months or days) In this community One day

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: 70

(c) City or town: Montgomery City (If outside city or town limits, write "RURAL") O

(d) Street No.: Star Route (If rural, give location) O

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME: Albert Thomas Hills

3. (b) If veteran, name war: _____ 3. (c) Social Security No.: _____

4. Sex: M O 5. Color or race: Wh 6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: _____ 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: Oct (Month) 13 (Day) 1965 (Year)

8. AGE: Years 1 Months 0 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation: Infant

11. Industry or business: _____

FATHER
12. Name: Albert W Hills O
13. Birthplace: Nodinger (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name: Bonnie Taylor
15. Birthplace: Shoshone (City, town, or county) Wyo (State or foreign country)

16. (a) Informant: Mrs A. W. Hills
(b) Address: Montgomery City Mo

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: 10-22-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Hannibal Mo

18. (a) Signature of funeral director: Berkley
(b) Address: Kirksville, Mo.

19. (a) 10-21-46 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 21 year 1946 hour 6 minute 35 P.M.

21. I hereby certify that I attended the deceased from Oct 21, 1946, to Oct 21, 1946; that I last saw him alive on Oct 21, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage — Duration: few weeks

Due to: Thrombocytopenic Purpura

Due to: _____

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings:
Of operations: N D A
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: O

23. Signature: E. B. Smith (M. D. ~~or other~~)

Address: Oct 21-46 Kirksville Mo Date signed 10-21-46

(Licensed Embalmer's Statement on Reverse Side)

SEP 22 1955

RECEIVED
District Health Officer No. 10
District File Number 10:46:1991
Date Filed OCT 31 1946

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 D E Riley

Licensed Embalmer No. 4181

P. O. Address Kirksville, 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.