No. 2
12-15
5-17-39
I X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 27 1947

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 3529

Registration District No. 3617 Primary Registration District No. 6076 Registrar's No. 117

**1. PLACE OF DEATH:**

(a) County St. Louis
(b) City or town Ucal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 108 days (Specify whether)
In this community Life years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Ood
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1138 Bayard 9
(If rural, give location) 1
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jeneral Jones HILL
3. (b) If veteran, name war —
3. (c) Social Security No.
4. Sex M 2
5. Color or race Col.
6. (a) Single, widowed, married, divorced S. D
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 3 (Month) 28 (Day) 1928 (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month January day 16
year 1947 hour 6 AM minute 0 A.M.

21. I hereby certify that I attended the deceased from 9/46, 19 46, to 1-16, 19 47, that I last saw h[im] alive on 1-15, 19 47; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chron. Pulmonary Tuberculosis | 1 Month |
| Due to: | |
| Due to: B2 | |
| 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.

8. AGE: Years 18 | Months 9 | Days 19 | If less than one day hr. min.
9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country) U
10. Usual occupation Bus Boy
11. Industry or business
FATHER 12. Name Jaines Anthony Hill
13. Birthplace — (City, town, or county) — (State or foreign country)
MOTHER 14. Maiden name Ida McCauley
15. Birthplace Muskogee Oklahoma (City, town, or county) (State or foreign country)
16. (a) Informant Robert Koch Hospital Records
(b) Address Ucal Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Boyd Bros
(b) Address 3907 Bayard St Louis
19. (a) 1-20-47 (Date received local registrar) (b) Ruth Gallenkamp (Registrar's signature)

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 U
23. Signature John F. Vollmer M.D. (M. D. or other)
Address Robert Koch Hospital Date signed 1-16-47

(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 Laurence E. Woodward

Licensed Embalmer No. 4341

P. O. Address St. Louis 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.**