

FILED OCT 29 1947 128

Registration District No.

Primary Registration District No.

5466

Registrar's No.

837A

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Rural - S Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
OZARK OSTEOPATHIC HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days - 16 hrs
(Specify whether years, months or days) same

3. (a) PRINT FULL NAME Female Infant - (Hill)

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

4. Sex Female Color or race w 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased 9-22-47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
6 16 hrs min.

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

10. Usual occupation

11. Industry or business

12. Name unknown

13. Birthplace 9

14. Maiden name Betty Lou Hill

15. Birthplace Dade Co. Mo

16. (a) Informant Charlie Hill

(b) Address Fair Play, Mo

17. (a) Springfield (b) Date thereof 29 23 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Cemetery

18. (a) Signature of funeral director Charles Hill

(b) Address Stockton, Mo

19. (a) 10-6-47 (b) W. S. Stanley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dade
(c) City or town Fair Play
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 22
year 1947 hour 100 minute 15 P.M.

21. I hereby certify that I attended the deceased from 9-15-47 to 9-22-47
that I last saw her alive on 9-22-47
and that death occurred on the date and hour stated above.

Immediate cause of death Starvation - refused to eat
Duration

Due to premature birth

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 15-9

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. S. Stanley (M. D. or other)

Address Stockton, Mo Date signed 9-23-47

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.....

Licensed Embalmer No.....

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.