FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 31 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42007

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 366

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

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town INDEPENDENCE (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 403 E ZAUN ST. (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 3 Mo - 23 da

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town INDEPENDENCE (If outside city or town limits, write "RURAL")
(d) Street No. 403 E ZAUN (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ——

3. (a) PRINT FULL NAME JAMES H. HILL (INFANT)
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male
5. Color or race Negro
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 Aug. 13, 1947 (Month) (Day) (Year)

8. AGE: Years — Months 3 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace INDEPENDENCE, MO (City, town, or county) (State or foreign country)
10. Usual occupation None
11. Industry or business ——
FATHER
12. Name ALLEN HILL
13. Birthplace CROW, MONTANA (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name FLORENCE STUCKY
15. Birthplace YAZAWOO, MISS. (City, town, or county) (State or foreign country)
16. (a) Informant (FATHER) Allen Hill
(b) Address 403 E. ZAUN
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Dec. 8, '47 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem. Indep., Mo.
18. (a) Signature of funeral director [signature]
(b) Address 1513 TROOST AVE. K.C. Mo.
19. (a) 12-8-47 (Date received local registrar) (b) [signature] (Registrar's signature) 354

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 6, year 47 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Dec. 4, 1947, to Dec 5, 1947; that I last saw him alive on Dec. 5, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy

PHYSICIAN
Underline the cause of 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 0

23. Signature W. H. Hickman (M. D. or other) M.D.
Address 401 1st Nat'l Bank Md. Independence, Mo. Date signed 12/10/47

Jefferson City Printing Co. (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 C. E. Davis

Licensed Embalmer No. 4417

P. O. Address St. C., 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.

S. No. 2D
3M—3 45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. JAN.

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 3 6 6

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence
(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
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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 James H. Hill

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race 13

6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 13 1947
(Month) (Day) (Year)

8. AGE: Years — Months 3 Days 23 If less than one day hr. min.

9. Birthplace (City, town, or county) No (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

20. DATE OF DEATH: Month Dec Day 6
year 1947 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

Bronchial Pneumonia

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 107

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 W. H. Hickman (M. D. or other) M.D.
Address Date signed

SUPPLEMENTARY

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

CLOSED JAN 9 1948

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