

FILED APR 26 1948

Registration District No. 175

Primary Registration District No. 3036

State File No.

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
808 Madison Ave
(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)

3. (a) PRINT FULL NAME ALICIA LUCILLE HILL

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

4. Sex Female / 5. Color or race W
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 March 3 1930
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
18 0 13 hr. min.

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

MOTHER FATHER

10. Usual occupation Unemployed
11. Industry or business.....
12. Name Benton Hill
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name Lucille Keener
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant Benton Hill
(b) Address Aurora, Missouri

17. (a) Burial (b) Date thereof 3/18/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director [Signature]

(b) Address Aurora, Mo

19. (a) March 20-48 (b) Ora Mc Natt
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence 55
(c) City or town Aurora /
(If outside city or town limits, write "RURAL")
(d) Street No. 808 Madison Ave /
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1948 hour 6 minute am

21. I hereby certify that I attended the deceased from 5:45 a.m.
March 16 1948 to 6:00 a.m. 16 1948

that I last saw him alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Due to prob. bacterial pneumonia Only
Due to.....

Other conditions Coronary atherosclerosis
(Include pregnancy within 3 months of death) obd.

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?

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

23. Signature [Signature] (M. D. or other)
Address 13 W. Olive St Date Mar 16/48

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

RECEIVED

District Health Officer No. 6;

District File Number 442-477

Date Filed APR 23 1948

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.....

Walter S. Cobb

....., Registered Apprentice No. 94

working under my personal supervision.

Signed

John H. King

Licensed Embalmer No. 3529

P. O. Address Aurora, Missouri.

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.

Registration District No. 175

Primary Registration District No. 3036

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Aurora
 (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)

3. (a) PRINT FULL NAME Alicia S. Hill

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

4. Sex F 5. Color or race W 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 _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business Invalid

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 1946
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-13209