

No. 3000  
-10-47  
5-17-39  
FD-1 3906

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28701

FILED AUG 31 1948  
Registration District No. 365

Primary Registration District No. 6339

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Washington

(b) City or town Caledonia Rural Belleview  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Caledonia, Mo. /  
(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 5 Months

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois

(c) City or town Cantwell  
(If outside city or town limits, write "RURAL")

(d) Street No. 1/2 Mt (If rural, give location)

(e) Citizen of foreign country? NO. (Yes of No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Louisa M. Hill

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 22  
year 1948 hour 1 minute 55 a.m.

4. Sex female / 5. Color or race white

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

6. (b) Name of husband or wife William R. Hill

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

7. Birth date of deceased July 27 1850  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 5 1948 to Aug 22 1948  
that I last saw her alive on Aug 15 1948  
and that death occurred on the date and hour stated above.

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

98	1	28	hr. min.
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Immediate cause of death

Due to apoplexy

Due to Senility

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation care of home

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_

12. Name Orval Mo. Cabe

13. Birthplace Unknown  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Mrs. Shelby Williams

(b) Address Caledonia, Mo.

17. (a) Burial (b) Date thereof 8-24-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Herod Cemetery

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Gas W. Buffum MD (M. D. or other)

Address Bismarck Mo Date signed 8-23-48

18. (a) Signature of funeral director E. Z. Boyer

(b) Address Desloge, Missouri

19. (a) 8-28-48 (b) Ella White  
(Date received local registrar) (Registrar's signature)

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

REIVED

Health Officer No. 4  
File Number 848-1077  
Date Filed 8-30-48

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 *J. T. Sawyer*  
Licensed Embalmer No. *3665*  
P. O. Address *Keosauqua 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.