

FILED FEB 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 917

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE 34</b>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>SPRINGFIELD</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>SPRINGFIELD</b>	
c. LENGTH OF STAY (in this place) <b>4 mos</b>		d. STREET ADDRESS (If rural, give location) <b>2040 N. NATIONAL</b>	
d. FULL NAME OF (If not in hospital, give name of institution, hospital or institution) <b>TROTTER NURSING HOME</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>CELIA</b>	b. (Middle)	c. (Last) <b>HILL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 31 1949</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE (1)</b>	8. DATE OF BIRTH <b>FEB. 12, 1872</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Month <b>2</b> Day <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IN THE HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>DANIEL P. HILL</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH R. MITCHELL</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS. NORA HILL Rt. #5 Spgfd. Mo.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hr</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Senile Dementia</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>arteriosclerosis</b> DUE TO (c) <b>Mixed Systolic Hypertension</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Securities at which she constantly bought &amp; cratched</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **several weeks Jan 30, 1949**, that I last saw the deceased alive on **1-30, 1949**, and that death occurred at **4 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Garrett Hogg M.D.</b>	23b. ADDRESS <b>1053 Rowan</b>	23c. DATE SIGNED <b>2-2-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>FEB. 2, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>ROBERSON PRAIRIE</b>	24d. LOCATION (City, town, or county) (State) <b>10 MILES NORTH OF SPGFD. MO.</b>
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DATE REC'D BY LOCAL REG. <b>2-2-49</b>	REGISTRAR'S SIGNATURE <b>W. Handley M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Klingner &amp; Co.</b>	ADDRESS <b>Spgfd. Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Ogle Stone Jr.*

Licensed Embalmer No. *4176*

P. O. Address *Springfield*

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.