

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
FILED MAR 25 1949 STANDARD CERTIFICATE OF DEATH

State File No. 8792

BIRTH NO. 49-222745 REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 3028 Registrar's No. 55

49
3-1
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY OR TOWN Carthage		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage	
d. FULL NAME OF HOSPITAL OR INSTITUTION McCune-Brooks Hospital		c. LENGTH OF STAY (in this place) 2 days	
		d. STREET ADDRESS (If rural, give location) 302 N. Garrison Ave.	

3. NAME OF DECEASED (Type or Print) GARY FRANCIS HILL			4. DATE OF DEATH (Month) (Day) (Year) March 16, 1949		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	
8. DATE OF BIRTH Mar 14, 1949		9. AGE (in years last birthday) 0		10. MONTHS 0	
11. BIRTHPLACE (State or foreign country) Carthage, Missouri		12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Howard Hill		13b. MOTHER'S MAIDEN NAME Norma Jean Burt		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Howard Hill, 302 N. Garrison, Carthage	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Inanition from late toxemia (preclampsia) in mother</u>		INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)	
				DUE TO (c)	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7730	

19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Mar 17, 1949, to Mar 16, 1949, that I last saw the deceased alive on Mar 16, 1949, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. G. Bond M.D.</u> (Degree or title)		23b. ADDRESS <u>Carthage, Mo.</u>		23c. DATE SIGNED <u>Mar 17 '49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Mar 17, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Barton County, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>Mar 18 '49</u>		REGISTRAR'S SIGNATURE <u>L. B. Clinton M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Knell Mortuary, Carthage, Mo.</u> ADDRESS	
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Per. 7-219-49 (L) (Send 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Robert H. Knell

Signed _____
Student Embalmer

Licensed Embalmer No. 4459

P. O. Address. Parthage

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.