

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **25927**Noted on Vital Statistics
FILED AUG 1 1949
Registration District No. **374**Primary Registration District No. **6272**Registrar's No. **23**

1. PLACE OF DEATH:

(a) County **North**
 (b) City or town **Rural - Allen Township**
 (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 **no** (Specify whether
 In this community **49 yrs**
 years, months or days)

3. (a) PRINT
FULL NAME**KATHERINE A. HILL**

3. (b) If veteran,

name war

3. (c) Social Security No.

4. Sex **2** 1 Color or race **W**
 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Andrew J. Hill**
 6. (c) Age of husband or wife if alive **29** years
 7. Birth date of deceased **May 29 1858**
 (Month) (Day) (Year)

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

91 **0** **10** hr. min.
 9. Birthplace **Perthshire Scotland**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Home wife**

11. Industry or business

12. Name **Robert Lochan**
 13. Birthplace **Scotland**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Mary Duff**
 15. Birthplace **Scotland**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Blanche Mathews**
 (b) Address **Grant City Mo**
 17. (a) **Burial** (b) Date thereof **6 10 1949**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **prairie chapel**18. (a) Signature of funeral director **Brame Bros**(b) Address **Deming Mo**19. (a) **July 22 1949** (b) **John E. Dawson**
 (Date received local registrar) (Registrar's signature)

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **North**
 (c) City or town **Rural** 113
 (If outside city or town limits, write "RURAL")
 (d) Street No. (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **8**
 year **1949** hour **4** minute **A.M.**

21. I hereby certify that I attended the deceased from **June 8**19 **49**, to **June 8**, 19 **49**that I last saw **her** alive on **June 7**, 19 **49**

and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial infarction****Myocardial infarction of heart**Duration **3**

Due to

Due to

Other conditions **97 yrs -**

(Include pregnancy within 3 months of death)

Major findings: **407**

Of operations

Of autopsy **no**

22. If death was due to external causes, fill in the following:

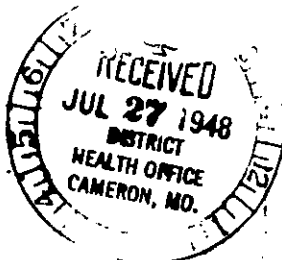
(a) Accident, suicide, or homicide (specify) **x**(b) Date of occurrence **x**(c) Where did injury occur? **x** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public

place? **x** (Specify type of place)While at work? **x** (e) Means of injury23. Signature **J. Rose MD** (M. D. or other)Address **St. Anthony's Hosp** Date signed **6-9-49**

PHYSICIAN

Underline the cause of which death should be charged statistically.



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 _____

Licensed Embalmer No. 2958

P. O. Address _____

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.