

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29469

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1065</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (In this place) <u>3 yrs. 11 mo. 1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		TOWN <u>D</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>				d. STREET ADDRESS (If rural, give location) <u>209 W. Nebraska St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>HARRY</u>		b. (Middle) <u>(none)</u>		c. (Last) <u>HILL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-19-1950</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>3-25-1884</u>	
9. AGE (In years last birthday) <u>66</u>		10. UNDER 1 YEAR Months <u>6</u> Days <u>24</u>		11. BIRTHPLACE (State or foreign country) <u>Fort Scott - Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Splitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing Co.</u>					
13a. FATHER'S NAME <u>Harrison Hill</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ross</u>		14. NAME OF HUSBAND OR WIFE <u>Glenn Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Lottie Hill - 209 W. Neb. St. Joseph</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterio-sclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Psychosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>6 years</u> <u>4221</u> <u>5 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-8-1946</u> , to <u>9-19-1950</u> , that I last saw the deceased alive on <u>9-19-1950</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. H. Marroway M.D.</u>		23b. ADDRESS <u>State Hospital No. 2.</u>		23c. DATE SIGNED <u>9-19-1950</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Sept 23 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ashland cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St Joseph Mo</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 23, 1950</u>		REGISTRAR'S SIGNATURE <u>W. B. Jenkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Beatrice May</u>		ADDRESS <u>818 Pacific</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed
Student Embalmer

Licensed Embalmer No. 4238

P. O. Address St. Joseph 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.