

FILED SEP 28 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3120A

BIRTH NO. _____ REG. DIST. NO. 261 PRIMARY REG. DIST. NO. 3048 Registrar's No. 192

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

1. PLACE OF DEATH
 a. COUNTY *Madawaska*
 b. CITY OR TOWN *Marquette*
 c. LENGTH OF STAY (In this place) *3 months*
 d. FULL NAME OF HOSPITAL OR INSTITUTION *St. Thomas Hospital*

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
 a. STATE *MO* b. COUNTY *Madawaska*
 c. CITY OR TOWN *Marquette, Me*
 d. STREET ADDRESS (If rural, give location) *0740*

3. NAME OF DECEASED
 a. (First) *Esther* b. (Middle) *L.* c. (Last) *Hill*

4. DATE OF DEATH (Month) (Day) (Year)
9 - 13 - 1950

5. SEX *F.*

6. COLOR OR RACE *W.*

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH *3-8-69*

9. AGE (In years last birthday) *81*
 IF UNDER 1 YEAR: Months *5* Days _____ Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife

10b. KIND OF BUSINESS OR INDUSTRY
Housewife

11. BIRTHPLACE (State or foreign country)
Me, Meade

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME
Leah's means

13b. MOTHER'S MAIDEN NAME
Martha Howard

14. NAME OF HUSBAND OR WIFE
M. S. Hill

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.
no

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mattie Scott 2526 1/2 St. Joseph

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) *Chronic Hypertension*
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) *Arteriosclerosis - Sclerosis*
 DUE TO (c) *Senility & Malnutrition*
 II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.
Epithelium of parathyroid glands

INTERVAL BETWEEN ONSET AND DEATH
42 2/3

19a. DATE OF OPERATION
 19b. MAJOR FINDINGS OF OPERATION
Parathyroid glands

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)

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 *8-21*, 19*50*, to *Sept 13*, 19*50*, that I last saw the deceased alive on *Sept 13*, 19*50*, and that death occurred at *9:30* m., from the causes and on the date stated above.

23a. SIGNATURE *W. R. Jackson, M.D.* (Degree or title)

23b. ADDRESS *Marquette, Me*

23c. DATE SIGNED *9-15-50*

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE *9-15-50*

24c. NAME OF CEMETERY OR CREMATORY *Weatherman*

24d. LOCATION (City, town, or county) (State)
Marquette, Me

DATE REC'D BY LOCAL REG. *9-16-50*

REGISTRAR'S SIGNATURE *Bess Holt*

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Haddick Phillips Marquette, Me



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

Natoy R. Phillips

Signed.....
Student Embalmer

Licensed Embalmer No. *1898*

P. O. Address *Starkley, MD*

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.