

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 20 1951

State File No. 26611

128

2000

Registrar's No. 705

BIRTH NO. _____		REG. DIST. NO. _____	PRIMARY REG. DIST. NO. _____	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY <b>GREEN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>DALLAS</b>		
b. CITY (If outside corporate limits, write RURAL and give township) <b>Springfield</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Louisburg</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>0300</b> <b>1</b>		

3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>Riley</b> c. (Last) <b>Hiler</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>8-15-1951</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>	8. DATE OF BIRTH <b>Sept-28-1875</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Jonas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>Aaron Hiler</b>		13b. MOTHER'S MAIDEN NAME <b>Halliday</b>	
14. NAME OF HUSBAND OR WIFE <b>Elsie May Hiler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Audrie Norman</b>		ADDRESS <b>Seattle Wash.</b>			

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Uraemia + Hemorrhage</b>		DUPLICATE (b) <b>Prostatectomy on stage</b>				
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) <b>Serulity 610X</b>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						

19a. DATE OF OPERATION <b>8-10-51</b>	19b. MAJOR FINDINGS OF OPERATION <b>Benzoin Hypertrophy prostate gland</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE	21b. PLACE OF INJURY (Specify) _____	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 **8-1-51**, 19**51** to **8-15**, 19**51**, that I last saw the deceased alive on **8-15**, 19**51**, and that death occurred at **10:45** a.m., from the causes and on the date stated above.

23a. SIGNATURE <b>W. Serull</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>Springfield Mo.</b>	23c. DATE SIGNED <b>8-16-51</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8/17-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	24d. LOCATION (City, town, or county) (State) <b>Warren Co. Kans.</b>
DATE REC'D BY LOCAL REG. <b>8-17-51</b>	REGISTRAR'S SIGNATURE <b>W.E. Handley</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Allen W. Vaughan</b> ADDRESS <b>Warrens MO</b>	

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

APR 1962  
1962-1962  
1962-1962

**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 *Allen W Vaughan*

Licensed Embalmer No. *4156*

P. O. Address *Urban, 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.