

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 2899  
Registrar's No. 0915FILED FEB 14 1952  
BIRTH NO. 4265-52

REG. DIST. NO. 310

PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		d. STREET ADDRESS (If rural, give location) 1032 Bond	
3. NAME OF DECEASED (Type or Print) a. (First) Twin #1 b. (Middle) c. (Last) Hill		4. DATE OF DEATH (Month) (Day) (Year) 1-9-52	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ( )		8. DATE OF BIRTH 1-9-52	
9. AGE (In years last birthday) 3 hrs		10. BIRTHPLACE (State or foreign country) St. Louis Mo.	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Eugene Hill		13b. MOTHER'S MAIDEN NAME Gloria York	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Gloria Hill	
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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity 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.	
19a. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) (Minute)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 774X	
22. I hereby certify that I attended the deceased from 1:45 AM 1-9-1952, to 3:00 AM 1-9-1952, that I last saw the deceased alive on 1-9-1952 and that death occurred at 3:00 PM, from the causes and on the date stated above.			
23a. SIGNATURE N. A. Harris, M.D. (Degree or title)		23b. ADDRESS 1536 Papine	
23c. DATE SIGNED 1-9-52		24a. BURL, CREMATION, REMOVAL (Specify) 1-31-52	
24b. DATE 1-31-52		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) St. Louis, Mo. (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	
DATE REC'D BY LOCAL REG. JAN 30 1952		ADDRESS 4104 Manchester Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

Licensed Embalmer No.....

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.