

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31319

State File No.

FILED OCT 14 1952

128

PRIMARY REG. DIST. NO. 2000 Registrar's No. 907

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO. 2000		Registrar's No. 907	
1. PLACE OF DEATH a. COUNTY GREEN				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY DALLAS			
b. CITY OR TOWN Springfield		c. LENGTH OF STAY (in this place) 13 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fair Grove, Rural		0300	
d. FULL NAME OF HOSPITAL OR INSTITUTION OSARK OSTEOPATHIC HOSPITAL				d. STREET ADDRESS (If rural, give location) R. I			
3. NAME OF DECEASED (Type or Print) HIRAM		a. (First) Green		b. (Middle) Hill		c. (Last)	
4. DATE OF DEATH 10 6 52		(Month)		(Day)		* (Year)	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH 10-18-1873	
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 11		1 DAY 18		IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own farm		11. BIRTHPLACE (State or foreign country) Miller County D		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Louis Hill		13b. MOTHER'S MAIDEN NAME Emily Atkinson		14. NAME OF HUSBAND OR WIFE SARAH Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no.		17. INFORMANT'S SIGNATURE OR NAME Carl Hill Red Top Mo ADDRESS			
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) Circulatory failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Post surgical shock DUE TO (c) advanced hydropneumothorax and nephrosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 10/6/52		19b. MAJOR FINDINGS OF OPERATION Hypertrophy of prostate 610x				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) m.		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 9/24 1952 to 10/6 1952 , that I last saw the deceased alive on 10/6 1952 , and that death occurred at 3:00 P.m. , from the causes and on the date stated above.							
23a. SIGNATURE Edna E. Webster (Degree or title) DO 2		23b. ADDRESS Springfield Mo		23c. DATE SIGNED 10/6/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10-9-1952		24c. NAME OF CEMETERY OR CREMATORY UNION MOUND		24d. LOCATION (City, town, or county) (State) Fair Grove, Missouri	
DATE REC'D BY LOCAL REG. 10-9-52		REGISTRAR'S SIGNATURE Edna Williamson		25. FUNERAL DIRECTOR'S SIGNATURE L. B. Jones, Buffalo, Missouri ADDRESS			

(License of Embalmer's Statement on Reverse Side)

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

DEC 16 1952

APR 9 1953

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RECEIVED
JAN 10 1953
BUREAU OF HEALTH

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

Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address *Buffalo 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.