

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

4303

State File No.

FILED JAN 17 1953

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 0040

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY St. Louis	b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Manchester	a. STATE Missouri	b. COUNTY New Madrid
c. LENGTH OF STAY (in this place) 2yrs4mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Postageville 0721	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Home		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle) Hill	c. (Last) Hill	4. DATE OF DEATH	(Month) 1	(Day) 6	(Year) 53
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 3/20/1874	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and State or Foreign Country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Willie B. Hill	13b. MOTHER'S MAIDEN NAME Caroline Sawyer	14. NAME OF HUSBAND OR WIFE N/A
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Pine Crest Home, Ballwin, Mo.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Generalized arteriosclerosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left Hemiplegia		6 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 33IX	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8/23, 1952 to 1-6, 1953, that I last saw the deceased alive on 1/24, 1953, and that death occurred at 10:20 P.M. from the causes and on the date stated above.

23a. SIGNATURE <i>R. Shesler</i>	(Degree or title)	23b. ADDRESS Kirkwood, Mo	23c. DATE SIGNED 1/6/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-6-53	24c. NAME OF CEMETERY OR CREMATORY* Wardell, Mo	24d. LOCATION (City, town, or county) (State)
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DATE RECD BY LOCAL REG. 1-6-53	REGISTRAR'S SIGNATURE <i>H. R. ...</i>	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington
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(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, 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.