

FILED DEC 12 1955

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. ....

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY                               |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |
| b. CITY OR TOWN <b>St. Louis</b>                             | c. LENGTH OF STAY (in this place) <b>2 1/2 days</b> | c. CITY OR TOWN <b>St. Louis</b>  | d. Is Residence within limits of a city or incorporated town? <b>Yes</b> <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>City Hospital</b> |   | e. STREET ADDRESS (If rural, give location) <b>5 775 Goodfellow Blvd</b>  |   |

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>William</b>  | b. (Middle) <b>Mckinley</b>       | c. (Last) <b>Hill</b>  | DATE OF DEATH (Month) (Day) (Year)<br><b>Nov. 25 1955</b> |
| 5. SEX <b>male</b>  | 6. COLOR OR RACE <b>White</b>     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>          | 8. DATE OF BIRTH <b>Oct. 8, 1900</b>                      |
| 9. AGE (In years last birthday) <b>55</b>   |                                   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>18</b>                              | IF UNDER 1 HR.<br>Hours <b></b> Min. <b></b>              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labourer</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign, Country) <b>Harrisburg Illinois</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                |

|   |   |  |
|---|---|--|
| 13a. FATHER'S NAME <b>Silas P. Hill</b>                                     | 13b. MOTHER'S MAIDEN NAME <b>Susan B. Sheffield</b> | 14. NAME OF HUSBAND OR WIFE <b>Ruby Hill</b>   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> | 16. SOCIAL SECURITY NO. <b>702-03-8704</b>          | 17. INFORMANT'S SIGNATURE OR NAME <b>Mattie Williams</b> ADDRESS <b>775 Goodfellow Bl.</b> |

|  |   |  |                                  |
|--|---|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   | MEDICAL CERTIFICATION                   |  | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Respiratory obstruction</b>  | DUE TO (b) <b>Carcinoma of the lung</b> |  |                                  |
| ANTECEDENT CAUSES  | DUE TO (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. |   |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)             |   |  |                                  |

|  |  |  |
|--|--|--|
| 19a. DATE OF OPERATION                                 | 19b. MAJOR FINDINGS OF OPERATION <b>163x</b>   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | 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 **Nov 1**, 19**55** to **Nov 25**, 19**55**, that I last saw the deceased alive on **Nov 25**, 19**55**, and that death occurred at **6:30 P.M.** from the causes and on the date stated above.

|  |   |   |
|--|---|---|
| 23a. SIGNATURE <b>Miles D. Miller M.D.</b> (Degree or title) | 23b. ADDRESS <b>City Hospital</b>               | 23c. DATE SIGNED <b>11/26/55</b>  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Reinterred</b>  | 24b. DATE <b>Nov. 27, 1955</b>                  | 24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem. Sikeston</b> (State) <b>Mo</b>   |
| DATE REC'D BY LOCAL REG. <b>NOV 28 1955</b>                  | REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Bull-Campbell Mortuary</b> ADDRESS <b>5165 Delmar</b> |

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

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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.....  
Signature of Student Embalmer

Signed..... *Neal Morris*

Licensed Embalmer No..... *36*  
*603 Boeneck's Dr*  
P. O. Address *Louisa, La 70357*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.