

FILED NOV 26 1956

STANDARD CERTIFICATE OF DEATH

State File No. 38903

BIRTH NO. _____ REG. DIST. NO. 241 PRIMARY REG. DIST. NO. 5858 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY Nodaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Nodaway	
b. CITY (If outside corporate limits, write RURAL and give town) Graham, rural		c. LENGTH OF STAY (In this place) 73 yrs	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		f. STREET ADDRESS (If rural, give location) 0740	

3. NAME OF DECEASED (Type or Print)	a. (First) LAWRENCE	b. (Middle) E	c. (Last) HILL	4. DATE OF DEATH (Month) (Day) (Year) 11 2 1956
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb 3, 1884	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	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 farming	11. BIRTHPLACE (City and State or Foreign Country) Graham, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm. N. Hill	13b. MOTHER'S MAIDEN NAME Rebecca J. Weir	14. NAME OF HUSBAND OR WIFE Mrs Faye Hill
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 494-40-8651	17. INFORMANT'S SIGNATURE OR NAME Mrs Faye Hill, Graham, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Under
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary disease DUE TO (c) Chronic Myocarditis		
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	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)	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 **Dec 19 48**, to **11-2, 1956**, that I last saw the deceased alive on **Jan 20, 1956**, and that death occurred at **11:30** m., from the causes and on the date stated above.

23a. SIGNATURE W.R. Jackson, M.D. (Degree or title)	23b. ADDRESS Marionville, Mo.	23c. DATE SIGNED 11/17/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 10	24b. DATE 11-24-1956	24c. NAME OF CEMETERY OR CREMATORY Graham Cemetery	24d. LOCATION (City, town, or county) (State) Graham, Mo.
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DATE REC'D BY LOCAL REG. 11-24-56	REGISTRAR'S SIGNATURE Bess Bolt	25. FUNERAL DIRECTOR'S SIGNATURE W.R. Jackson ADDRESS Marionville, Mo.
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

1740

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DEC 28 1956

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 *G. M. Atchison*

Licensed Embalmer No... *237*

P. O. Address *Maryville*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.