

FILED JAN 14 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

471

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 2

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Callaway</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fulton</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Fulton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>204 W. 7th St.</u>		Length of stay in lb <u>6 Months</u>		d. STREET ADDRESS <u>204 W 7th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Lillian Middle M. Last Hill</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1884</u>	
9. AGE (In years last birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance agency</u>		100. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and state or country) <u>Benton, Wisconsin</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and state or country) <u>Benton, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Fawcett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Pedley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>DK</u>		17. INFORMANT Address <u>Mrs. Frank Ollivier Fulton, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - mild 4200</u>						INTERVAL: BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>5/3/56</u> to <u>1-9-57</u> and last saw her <sup>her</sup> <sub>alive</sub> on <u>1-9-57</u> Death occurred at <u>12:30 pm 1/9/57</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Tom Brewer MD</u>				22b. ADDRESS <u>Fulton, Mo.</u>		22c. DATE SIGNED <u>1-9-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan-12-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand Island Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Grand Island Nebraska</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Hallace Funeral Home, Fulton, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Jan-9-1957</u>		26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
7-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Actor R. Masum*

Licensed Embalmer No. *79*

P. O. Address *Fulton,*

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.