

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 17 1957

24329

State File No. ....

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                 |  |                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                        |  |
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| BIRTH NO. ....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | REG. DIST. NO. <u>140</u>       |  | PRIMARY REG. DIST. NO. <u>3024</u>                                                                                                                                                                                                                                           |  | Registrar's No. <u>57</u>                                                  |  |                                                                                                        |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Howard</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                 |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>                                                                                                                                    |  |                                                                            |  |                                                                                                        |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                 |  | c. LENGTH OF STAY (in this place) <u>8 days</u>                                                                                                                                                                                                                              |  | c. CITY OR TOWN <u>Fayette</u>                                             |  |                                                                                                        |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lee Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                 |  | e. STREET ADDRESS (If rural, give location) <u>701 North Church</u>                                                                                                                                                                                                          |  |                                                                            |  |                                                                                                        |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>George</u> b. (Middle) <u>Washington</u> c. (Last) <u>Hill</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                 |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 22 1957</u>                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                        |  |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>                                                                                                                                                                                                  |  | 8. DATE OF BIRTH <u>June 15, 1869</u>                                      |  |                                                                                                        |  |
| 9. AGE (In years last birthday) <u>88</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10. IF UNDER 1 YEAR Months Days |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Rocheport Mo.</u>                                                                                                                                                                                                      |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                 |  |                                                                                                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                 |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>                                                                                                                                                                                                                            |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Rocheport Mo.</u>    |  |                                                                                                        |  |
| 13a. FATHER'S NAME <u>Harvey Hill</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                 |  | 13b. MOTHER'S MAIDEN NAME <u>Mary Ridgeway</u>                                                                                                                                                                                                                               |  | 14. NAME OF HUSBAND OR WIFE                                                |  |                                                                                                        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                 |  | 16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                      |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Elma Harlan Boonville Mo.</u> |  |                                                                                                        |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.<br><br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u><br><br>ANTECEDENT CAUSES <u>arteriosclerosis</u><br><br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) <u>none</u><br><br>DUE TO (c) <u>none</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br>INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u><br><u>inlet.</u> |  |                                 |  | 19a. DATE OF OPERATION <u>none</u>                                                                                                                                                                                                                                           |  |                                                                            |  | 19b. MAJOR FINDINGS OF OPERATION <u>331x</u>                                                           |  |
| 20. AUTOPSY? <u>2</u><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                 |  | 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Natural</u>                                                                                                                                                                                                                      |  |                                                                            |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, 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 <u>July</u> , 19 <u>55</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>57</u> , and that death occurred at _____ m., from the causes and on the date stated above. |  |                                                                            |  |                                                                                                        |  |
| 23a. SIGNATURE (Degree or title) <u>Wm. J. Lang Jr. M.D.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                 |  | 23b. ADDRESS <u>Lee Hospital, Fayette, Mo.</u>                                                                                                                                                                                                                               |  |                                                                            |  | 23c. DATE SIGNED <u>6-24-57</u>                                                                        |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                 |  | 24b. DATE <u>June 24 1957</u>                                                                                                                                                                                                                                                |  |                                                                            |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Rocheport</u>                                                    |  |
| 24d. LOCATION (City, town, or county) (State) <u>Rocheport Missouri</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                 |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ralph A. Carr Fayette Mo.</u>                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                        |  |
| DATE REC'D BY LOCAL REG. <u>6/22/57</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                 |  | REGISTRAR'S SIGNATURE <u>Mary L. Shell</u>                                                                                                                                                                                                                                   |  |                                                                            |  | 5. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ralph A. Carr Fayette Mo.</u>                               |  |

(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, ~~by~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*Ralph A Carr*

Licensed Embalmer No. 334

P. O. Address Fayette

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.