

Health, Welfare, Public Service

FILED FEB 4 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

587

STATE FILE NUMBER

Registration District No. #67

Primary Registration District No. 5260

Registrar's No. 4

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| 1. PLACE OF DEATH a. COUNTY Christian | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Christian | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN So. Lynn Township | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN Forsyth, RRD |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence | | Length of stay in 1b 96 years | d. STREET ADDRESS 8 miles SW of Chadwick |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First HANNAH Middle ELIZABETH Last "POLLY" HILTON | | | 4. DATE OF DEATH Month Jan. Day 12, Year 1958 | |
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|-------------------------|----------------------------------|---|--|--|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 23, 1861 | 9. AGE (In years by birthday) 96 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
|-------------------------|----------------------------------|---|--|--|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY - - - - | 11. BIRTHPLACE (City and state or country) Christian Co., Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Wyatt Bilyeu | 13b. MOTHER'S MAIDEN NAME Jane Sinclair | 14. NAME OF HUSBAND OR WIFE William J. Hilton |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Ellis Hilton, Forsyth, Missouri |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Uremic Poisoning | |
| | DUE TO (c) Arteriosclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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|---|---|--|---|--------------------------|--------------------------|
| 20c. TIME OF INJURY Hour 6:15 Month, Day, Year Jan. 12, 1958 | 20d. INJURY OCCURRED WHILE AT <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 Spokane, Mo. | COUNTY Spokane | STATE Missouri |
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| 21. I attended the deceased from Jan. 1-1958 to Jan. 12-1958 and last saw her alive on Jan. 10-1958 Death occurred at 6:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <i>Dr. Warren H. Wilson, M.D.</i> | (Degree or title) | 22b. ADDRESS Spokane, Mo. | 22c. DATE SIGNED 1-22-58 |
|---|-------------------|-------------------------------------|------------------------------------|

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1/15/1958 | 23c. NAME OF CEMETERY OR CREMATOR Spokane Cemetery | 23d. LOCATION (City, town, or county) (State) Spokane, Missouri |
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| 24. FUNERAL DIRECTOR <i>J. Dean Harris</i> | ADDRESS Clever, Mo. | 25. DATE RECD. BY LOCAL REG. Jan. 20/58 | 26. REGISTRAR'S SIGNATURE <i>Nansie Day</i> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Jean Harris*

Licensed Embalmer No. *4390*

P. O. Address *Cleveland, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.