

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008404
STATE FILE NUMBER

FILED MAR 23 1959

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 123

300
-57 8

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Centralia</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hosp</u>		Length of stay in 1b <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>Way Nursing Home</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MYRA</u> Middle <u>HILLZER</u> Last <u>HILLZER</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 9-1866</u>	9. AGE (In years past birthday) <u>93</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Boone County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jim Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</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>None</u>	17. INFORMANT <u>John Hillzer</u>		Address <u>Centralia, Missouri</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>Heart Failure</u>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic Heart Disease</u>				
		DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture R Hip</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>	
20a. ACCIDENT <input checked="" 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.) <u>Fell at Way Rest Home</u>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year <u>3-16-1959</u>				
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 <u>Centralia</u>		COUNTY <u>Boone</u>	
				STATE <u>Missouri</u>		
21. I attended the deceased from <u>3-16-1959</u> to <u>3-18-1959</u> and last saw her alive on <u>3-18-1959</u> Death occurred at <u>Boone County Hosp</u> <u>3 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Paul Q. Ballew M.D.</u> (Degree or title)			22b. ADDRESS <u>Columbia MO</u>		22c. DATE SIGNED <u>3/19/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centralia Cemetery</u>		23d. LOCATION (City, town, or county) <u>Centralia, Missouri</u>	
24. FUNERAL DIRECTOR <u>Paul Q. Ballew</u>			ADDRESS <u>Centralia, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Mar 19 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R. E. Palmer</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

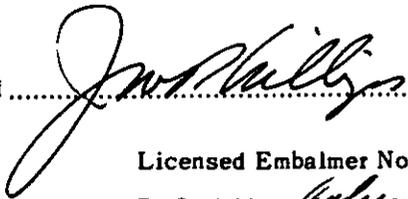
APR 30 1959

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



Licensed Embalmer No. 4897

P. O. Address Columbia, Md.

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.