

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008482

STATE FILE NUMBER

APR 6 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 329

300
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph <i>1117</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital		Length of stay in 1b 58 years.	d. STREET ADDRESS (If outside, give location) 1404 S. 30th Street
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Lester Middle Last Hillix	4. DATE OF DEATH Month March Day 29 Year 1959
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5. SEX Male <i>6</i>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1887	9. AGE (In years) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) New Market, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME William Hillix	13b. MOTHER'S MAIDEN NAME Fannie Dye	14. NAME OF HUSBAND OR WIFE -----
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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 G. G. (Gus) Hillix	Address St. Joseph, Mo.
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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) <i>Pulmonary Embolus</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Benign Hypertrophy of Prostate</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>610X</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>about 30 min.</i> <i>Unknown</i>
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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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 a.m. p.m.	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 COUNTY STATE
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21. I attended the deceased from Death occurred at <i>2:00 P.</i> <i>Mar 23, 1959</i> <i>Mar 29, 1959</i> and last saw ^{her} him alive on <i>Mar. 29, 1959</i> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>Maxwell Day, M.D.</i>	(Degree or title)	22b. ADDRESS <i>109 N 7th St. Joseph,</i>	22c. DATE SIGNED <i>3-30-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Mar. 31, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Ridge Cemetery</i>	23d. LOCATION (City, town, or county) <i>Weston, Missouri.</i>	(State)
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24. FUNERAL DIRECTOR <i>Meyerhofer, Fleeman</i>	ADDRESS <i>St. Joseph, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Mar. 31, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clara Eardell</i>
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All diseases in Part I must be causally related.
 Dr. Maxwell Day
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

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 *Alfred B. Harrington*

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Missouri

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.