MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

'59 043753

STATE FILE NUMBER

FILED VS JAN - 4 1960

AMENDED

Registration District No. 93 Primary Registration District No. ____ Registrar's No. 59-99

1. PLACE OF DEATH
a. COUNTY: Dade
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Smith TWP
Length of stay in 1b: yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: So Greenfield Rtl
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Dade
c. CITY OR TOWN: Smith TWP
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): So Greenfield RTl
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Hannah; Middle Elizabeth; Last Hill

4. DATE OF DEATH: Month Dec; Day 19; Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Jan 30, 1872

9. AGE (last birthday): 87

IF UNDER 1 YEAR: Months 10; Days 19; IF UNDER 24 HR: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Farner

11. BIRTHPLACE (City and state or country): Mo

12. CITIZEN OF WHAT COUNTRY: usa

13a. FATHER'S NAME: James McClure

13b. MOTHER'S MAIDEN NAME: Delia McGeehee

14. NAME OF HUSBAND OR WIFE: Samual Hill

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 Address: Mrs Ben Gorman So Greenfield Mo. rtl

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Malnutrition	6 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cancer of Stomach	1 1/2 yr
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 2-24-59, to 12-19-59 and last saw (her) him alive on 11-27-59

Death occurred at 7:00p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Ethan W. Taylor M.D.

22b. ADDRESS: 807 Main St. Lockwood Mo

22c. DATE SIGNED: 12/22/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Dec 22 1959

23c. NAME OF CEMETERY OR CREMATORY: Kings Point

23d. LOCATION (City, town, or county) (State): Dade Co Mo.

24. FUNERAL DIRECTOR ADDRESS: Allison Funeral Home Greenfield Mo.

25. DATE RECD. BY LOCAL REG.: 12/28/1959

26. REGISTRAR'S SIGNATURE: J. C. Canada

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — MEDICAL CERTIFICATION — DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed W.R. Collison

Signature of Student Embalmer

Licensed Embalmer No. 4404

P. O. Address Greenfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.