

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. ~~FILED~~ VS JAN - 4 1960 *28*

'59 0 4 3 9 1 4  
STATE FILE NUMBER

Registration District No. *2000* Primary Registration District No. *2000* Registrar's No. *1410*

RENDERED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>SPRINGFIELD</b>		Length of stay in 1b <b>16 YRS.</b>	c. CITY OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>936 S. DELAWARE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CLARK</b> Middle <b>WALLACE</b> Last <b>HILL</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>26</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/01</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARKING LOT OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BILL PARKING SERVICE - WEST PLAINS, MO.</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>	
13a. FATHER'S NAME <b>WALLACE M. HILL</b>		13b. MOTHER'S MAIDEN NAME <b>MATTIE BRIDGES</b>		14. NAME OF HUSBAND OR WIFE <b>EMILY HILL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>498-24-5504</b>		17. INFORMANT Address <b>MRS. EMILY HILL, SPRINGFIELD, MO</b>	
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>Liver Cirrhosis, nutritional</i> <i>portal vein thrombosis</i> <i>hepatomegaly &amp; splenic vein thrombosis</i> <i>Bacterial Endocarditis, Stigely Indistended</i> <i>Pulmonary Fibrosis, non-tuberculous</i> DUE TO (b) <i>acute Hemorrhagic Cystitis</i> DUE TO (c) <i>acute Hemorrhagic Cystitis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>ascites, malnutrition</i>					INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <i>none</i> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <i>none</i>		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 <b>10-16-59</b> to <b>12-26-59</b> and last saw him alive on <b>12-26-59</b> Death occurred at <b>2:15 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>W. Paul, M.D.</i> (Degree or title)			22b. ADDRESS <i>609 Cherry, Springfield Mo</i>		22c. DATE SIGNED <i>12/26/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/28/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WEST PLAINS, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>H.H. LOHMEYER, SPRINGFIELD, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>12-28-59</b>		26. REGISTRAR'S SIGNATURE <i>Effie E. Melton</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 *H. M. C. Cannon*

Licensed Embalmer No. 2727

P. O. Address *Springfield*

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.