

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

17334

**1. PLACE OF DEATH**

County Jackson  
Township Kaw  
City Kansas

Registration District No. 399  
Primary Registration District No. 100

File No. \_\_\_\_\_  
Registered No. 2307  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Old City Hosp St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) 1515 E 10 St Length of residence in city or town where death occurred yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. \_\_\_\_\_ How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da. \_\_\_\_\_ (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Chief

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-22-22

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>6</u>	<u>3</u>	<u>25</u>	<u>2</u>

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Schoolboy  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

PARENTS

10. NAME OF FATHER Robert Hillman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ark (STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Rosie Werner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) La (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Rosie Hillman (Address) 1515 E 10 St

15. FILED 725 28 M. M. Crowe REGISTRAR user

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-17-28

17. I HEREBY CERTIFY That I attended deceased from 5-17-28 to 5-22-28 1928 that I last saw him alive on 5-22-28 and that death occurred, on the date stated above, at 945 min.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Epidemic Cerebro spinal Meningitis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 da.

CONTRIBUTORY (SECONDARY) 24 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: 1515 E-10 St.

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
LABORATORY & CHEMICAL TESTS Chemical tests  
(Signed) Howard M. Smith M.D.  
5718, 1928 (Address) Kle 200

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Highland DATE OF BURIAL 5-26-28

20. UNDERTAKER AB Moore ADDRESS 1820 E 18

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

