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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29528

Registration District No. 774 Primary Registration District No. 4465 Registrar's No. 995

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County St. Francis Co.
(b) City or town Flat River
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Marye Hilland
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Norman Hilland 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Sept 1 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 6 If less than one day hr. _____ min. _____

9. Birthplace Silver Lake, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home maker

11. Industry or business _____

MOTHER FATHER { 12. Name Mr. McClain
13. Birthplace Mo
14. Maiden name Don't know
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Floyd N. Hilland
(b) Address Flat River, Mo.

17. (a) Burial (b) Date thereof 8/9/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parkview Cem

18. (a) Signature of funeral director C. A. Cozart
(b) Address Farmington, Mo.

19. (a) 8/10/40 (b) R. B. Starnes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Francois
(c) City or town Flat River
(If outside city or town limit, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 7 1940
year _____ hour _____ minute 1:55 P.M.
21. I hereby certify that I attended the deceased from Aug 5
1940 to Aug 7 1940
that I last saw her alive on Aug 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. H. Applebury (M. D. or other) MD
Address Flat River Mo Date signed 8-8-40

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.....

~~me~~ me

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

C. H. Cozear

Licensed Embalmer No. *4084*

P. O. Address *Farmington Mo*

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 29528
Registrar's No. 975

Registration District No. 774

Primary Registration District No. 4465

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Flat River
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Mary A. Welland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) ~~Single, widowed, married,~~
~~divorced, Married~~

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if
alive _____ years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 6 If less than one day
hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/9/40 (Date received local registrar) (b) C. H. Barrer (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month aug day 7
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur?: (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury _____

23. Signature C. H. Happleberry (M. D. or other) _____

Address Flat River Date signed _____

MISSOURI STATE BOARD OF HEALTH

SUPPLEMENTAL

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

