

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 29 1947
Registration District No. 343

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30094
Registrar's No. 32

Primary Registration District No. 6154

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

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Essex, Mo. R. 2
(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 _____)

3. (a) PRINT FULL NAME Lawrence Albert Hill,
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Golda Hill,
6. (c) Age of husband or wife if alive 49 years
7. Birth date of deceased Aug. 16. 1895
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 11 29 hr. min.

9. Birthplace Essex, R. 1 Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Farmer

MOTHER FATHER { 12. Name Wm. C. Hill

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

14. Maiden name Elitha Ellen Sanders.

15. Birthplace Essex, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Golda Hill.

(b) Address Essex, Mo. R. 2

17. (a) Burial (b) Date thereof Aug. 17. 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Taylor Cemetery

18. (a) Signature of funeral director Watkins Funeral Ser.

(b) Address Dexter, Mo.

19. (a) Aug. 22. 47 (b) Kate Hawley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Essex, R. 2.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15
year 1947 hour 2 minute 08 P.M.

21. I hereby certify that I attended the deceased from July 25. 47
19. Aug. 15. 47 19. _____
that I last saw him alive on Aug. 15. 47 19. _____
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia J. B.
Due to _____
Due to _____

Other conditions Embolic of Livers
(Include pregnancy within 3 months of death)

Major findings: Of operations 38
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 [Signature] (M. D. of other) _____
Address [Address] Date Aug 20

RECEIVED

District Health Office No. 2,

District File Number 847-8130

Date Filed 8-26-47

AUG 29 1947

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Lynna Steele

Licensed Embalmer No. 2476

P. O. Address Hexter 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, fact should be so stated above.