

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025175

STATE FILE NUMBER

FILED JUL 28 1958

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 740

Health,
& Welfare
Public
Service
\$
300
1-57

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|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Springfield 0396 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | Length of stay in lb 7 Days | d. STREET ADDRESS (If outside, give location) 1939 W. Chestnut Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL JAMES HILL | | | 4. DATE OF DEATH Month Day Year July 24, 1958 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 July 1958 |
| 9. AGE (In years last birthday) 0 | | IF UNDER 1 YEAR Months 0 Days 7 | IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY Infant | 11. BIRTHPLACE (City and state or country) Springfield, Mo. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME Harold Hill | |
| 13b. MOTHER'S MAIDEN NAME Wilma Cloven | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 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. No | 17. INFORMANT Hospital Records Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus DUE TO (b) Post-Surgery for: DUE TO (c) Meconium Ileus with perforation and obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5872 | | | INTERVAL BETWEEN ONSET AND DEATH 10 min. 7 days |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 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 7-18-58 to 7-24-58 and last saw him live on 7-24-58 Death occurred at 11:30 P. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE W. O. Overcup M.D. (Degree or title) | | 22b. ADDRESS Springfield, Missouri | 22c. DATE SIGNED 7-25-58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 7-25-58 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri |
| 24. FUNERAL DIRECTOR J. Klingner + Co. Spfld. Mo. ADDRESS | | 25. DATE RECD. BY LOCAL REG. 7-25-58 | 26. REGISTRAR'S SIGNATURE Effie S. Melton |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Student _____
Signature of Student Embalmer

Signed *Ogle Stone Jr.*

Licensed Embalmer No. *4176*
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.