

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7307**
Registrar's No. **3**

FILED MAR 2 1942

Registration District No. **577** Primary Registration District No. **6-775-**

1. PLACE OF DEATH:

(a) County **Monticau**
(b) City or town **State Street Hwy**
(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
In this community **all his life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Archie Hubert Hill**

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

4. Sex **Male** 5. Color or race **X** 6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Jospha** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased: **June 15 1891**
(Month) (Day) (Year)

8. AGE: Years **50** Months **7** Days **15** If less than one day hr. min.

9. Birthplace **Monticau Mo**
(City, town or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Newton Hill**
13. Birthplace **Monticau Mo**
(City, town or county) (State or foreign country)
14. Maiden name **Jessie Barber**
15. Birthplace **Monticau Mo**
(City, town or county) (State or foreign country)

16. (a) Informant **Jospha Hill**

(b) Address **California Mo**

17. (a) **Burial** (b) Date thereof **2/2/42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Flag Springs**

18. (a) Signature of funeral director **Walter H. Sullivan**

(b) Address **California Mo**

19. (a) **2-4-42** (b) **W. H. Sullivan**
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** County **Monticau**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **31**
year **1942** hour **10** minute **10 A** M.

21. I hereby certify that I attended the deceased from **Dec 12**, 19**41**, to **Jan 31**, 19**42**
that I last saw him alive on **Jan 29**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerosis**

Due to

Due to

Other conditions (Include pregnancy, within 3 months of death) **97**

Major findings: Of operations

Of autopsy

Duration

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 **J. P. Burke** (M. D. or other)

Address **California Mo** Date signed **2/2/42**

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

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MAR 3 1942

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 W E Friedman
Licensed Embalmer No. 2854
P. O. Address California 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.