

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

Do not use this space
27183
~~7182~~

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Law Primary Registration District No. 1002 Registered No. _____
 City Kansas City (No. 4130) Mercier St. _____ Ward _____

2. FULL NAME

Lillian Lenora Hildebrand
 (a) Residence. No. 4130 Mercier St. 7 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 44 yrs. mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emil O. Hildebrand

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 24, 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
65 | 6 | 12 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (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) _____

10. NAME OF FATHER John M. Keith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Elizabeth Chalmers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Unknown

14. INFORMANT Emil O. Hildebrand
 (Address) 41-30 Mercier

15. FILED 9/7 27 M. M. Corneil asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 6 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Sept 6, 1927
 that I last saw him alive on Sept 6, 1927, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
93C Heart failure following cerebral pneumonia
92A pneumonia [Right Cerebral Hemorrhage]
107A (duration) _____ yrs. 1 1/2 mos. _____ ds.

CONTRIBUTORY (SECONDARY) Essential Hypertension
 (duration) _____ yrs. 2 or more mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? 90B
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Routine laboratory findings
 (Signed) G. H. Hone, M. D.

(Address) Rt. 1, Kansas City, Mo.
 *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 Forest Hill DATE OF BURIAL Aug 8 1927

20. UNDERTAKER D. H. Newcomer's Sons ADDRESS St. Louis, Mo.

N. E.—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.

RECORDED

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