

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

Do not use this space.

15018

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **2934**

City **St. Louis**

(No. **2603**)

Rauschenbach

St.

Ward)

2. FULL NAME

Margaret Hillenkoetter

(a) Residence. No. **2603 Rauschenbach St.**

2 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U.S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Divorced

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Wm Korlsek

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

Jan. 12, 1895

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

43

2

25

8. OCCUPATION OF DECEASED

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

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

Self

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Louis

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Wm H Hillenkoetter

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

U.S.

14.

INFORMANT (Address)

**Albert Hillenkoetter
2723 Jennings Ave**

15.

FILED

APR -9 1928

Ray C Stanley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

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

Apr. 7, 1928

17.

I HEREBY CERTIFY, That I attended deceased from

5/7

1928

to

4/7

1928

that I last saw her alive on **4/7**, **1928**, and that death occurred, on the date stated above, at **7:50 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23H

131

95c

(duration) **3** yrs. **8** mos. **13** ds.

CONTRIBUTORY (SECONDARY)

**acute myocardial infarction (?)
general anoxia (duration) ? yrs. 1 mos. 1 ds.**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... **no** DATE OF..... **✓**

WAS THERE AN AUTOPSY..... **no**

WHAT TEST CONFIRMED DIAGNOSIS..... **Clinical**

(Signed) **Luke B. Pierson**, M. D.

4/9, 1928 (Address) 5118 Jennings Rd.

*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

DATE OF BURIAL

St Johns Cem

Apr 10 1928

20. UNDERTAKER

ADDRESS

A Keon L & N. Co

3707 W Grand Blvd

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—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.

