

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.

FEB 19 1935

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

Do not use this space.

1238

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 0  
 Township St. Ann Primary Registration District No. 1002 Registered No. 1002  
 City St. Louis, Mo. (No. General Hosp. #2 St. 3rd Ward)

2. FULL NAME

Hillman, Julius  
 (a) Residence, No. Helping Hand St. Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 5 1/2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widower</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>WIFE</u> or		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1-15-1866</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>11</u>
	DAYS <u>20</u>	If LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>None</u>	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Va.</u>		
FATHER	13. NAME <u>Tom Gyling</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Va.</u>	
MOTHER	15. MAIDEN NAME <u>Pelle (?)</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Va.</u>	
17. INFORMANT <u>Record Clerk</u> (ADDRESS) <u>General Hospital #2</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Keeds mo</u> DATE <u>1-10</u> 19 <u>35</u>		
19. UNDERTAKER <u>H.B. Moore</u> (ADDRESS) <u>1820 E 18</u>		
20. FILED <u>Jan 9</u> 19 <u>35</u> M. M. <u>Cosum</u> <u>Asst. Registrar.</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-5 1935

22. I HEREBY CERTIFY, That I attended deceased from 12-21, 1934, to 1-5, 1935

I last saw him alive on 1-5, 1935. Death is said to have occurred on the date stated above, at 2:30 P.M.

The principal cause of death and related causes of importance were as follows:  
Acute Gangrenous Cystitis of Retention  
(result of Infection or gonococcus)

Other contributory causes of importance:  
Hypertrophied Prostate

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) J. O. Jones M. D.  
 (Address) General Hosp. #2

