

MO FEB 23 1939

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

2221
Do not use this space.

1. PLACE OF DEATH *Franklin 2*
 (a) County *Boone* Registration District No. *292*
 (b) Township *Boone* Primary Registration District No. *5410* Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *Mary Marie Hildebrand*
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 26 - 1874*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 5 10
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. *Home work*
 10. Date deceased last worked at this occupation (month and year) *2 - 4 - 1939* 11. Total time (years) spent in this occupation *all*
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Franklin Mo*
 FATHER 13. NAME *Henry Hildebrand*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*
 MOTHER 15. MAIDEN NAME *Marquet Drees*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*
 17. INFORMANT (ADDRESS) *Mrs Frank Schure Newkoven Mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Boone Cem* DATE *7 - 27 - 1939*
 19. FUNERAL DIRECTOR (ADDRESS) *W. Le Fertig, Dan Newkoven Mo*
 20. FILED *Feb 7 1939* *Jeffie Gramma* Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 5 1939*
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *10 A. m.*
 The principal cause of death and related causes of importance were as follows:
Coronary Insufficiency
 Other contributory causes of importance: *Thromboses of the*
 Name of operation *none* Date of _____
 What test confirmed diagnosis? *Coronary* Was there an autopsy? *no*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *not* Date of injury _____, 19____
 Where did injury occur? *at home* (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. *in home*
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify _____
 (Signed) *Wm. P. Hoffa* *Coronary*
 (Address) *Sullivan Mo*

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.

STATEMENT BY LICENSED EMBALMER

I, Earl Frestig, Licensed Embalmer No. 3385

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

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.)