

REG'D AUG 11 1939 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: **1003**  
(a) County \_\_\_\_\_  
(b) City or town St. Louis Mo  
(c) Name of hospital or institution: \_\_\_\_\_  
4952 Magnolia Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 45 Years years, months or days

3. (a) PRINT FULL NAME Theresa Hillebrand  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Joseph M Hillebrand  
6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Jan 15 1879  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 5 23 hr. min.

9. Birthplace Fulda Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business at her home

12. Name Frederick Bloeser

18. Birthplace Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Unkonn

15. Birthplace Unkonn Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph M Hillebrand

(b) Address 4952 Magnolia Ave

17. (a) Burial (b) Date thereof 7 11 39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old St. Peter Paul

18. (a) Signature of funeral director Kriegshauser Und

(b) Address 4228 So. Kinghighway Blvd

19. (a) Jul 10 1939 (b) \_\_\_\_\_  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 13  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4952 Magnolia Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8  
year 1939 hour 5 minute 10 P. M.

21. I hereby certify that I attended the deceased from Sept 1938 to July 8 1939;  
that I last saw her alive on July 8 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation

Due to Mitral Stenosis

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Carl H. New (M. D. or other)

Address 2604 Washington Date signed 7-8-39

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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.

USE PREVIOUS EDITIONS OF THIS FORM—BLACK INK—MAKE A PERMANENT RECORD

Je 1800  
3604 Washington

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**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 *Reinhold K. Lohmann*

Licensed Embalmer No. 3395

P. O. Address.....

**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, above space should be left blank.**