DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24254

REC'D AUG 11 1939

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 6527

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST JOHNS Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County ST LOUIS

(c) City or town OVERLAND ~~RURAL~~ NR
(If outside city or town limits, write "RURAL")

(d) Street No. 3543 MARSHALL AVE
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME THOMAS HILES 420

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife EMMA

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased APRIL (Month) 24 (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
65	3	0	hr. min.

9. Birthplace CHAMOIS MO (City, town, or county) 0 (State or foreign country)

10. Usual occupation FUEL MAN 0

11. Industry or business M K T RAILROAD 0

FATHER
12. Name THOMAS L. HILES 1
13. Birthplace (City, town, or county) MO. (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. LeRoy Glover
(b) Address 3543 Marshall

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof JULY (Month) 26 (Day) 1939 (Year)
(c) Place: burial or cremation WAINWRIGHT Mo

18. (a) Signature of funeral director Cullen & Kelly
(b) Address 1416 N. Taylor Ave.

19. (a) JUL 25 1939 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 24th year 1939 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 1, 1939, to July 24, 1939; that I last saw him alive on July 24, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis, chronic	2 yrs
Due to	
Due to	
Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death)	10 yrs

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) M.D.
Address 402 Lister Bldg Date signed 7-25-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 I X19511

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 Clement McNeary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.