

WHITE PLAIN, 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.

JUL 15 1940

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

21703  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Barren Registration District No. 303  
 (b) Township Herrman Primary Registration District No. 482  
 (c) City Herrman (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME John F. Hillebrand  
 (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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Winnie Hillebrand  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5 - 1864  
 7. AGE YEARS 76 MONTHS 5 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marionville, Mo.  
 FATHER 13. NAME Henry Hillebrand  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 MOTHER 15. MAIDEN NAME Caroline Kestrey  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany  
 17. INFORMANT Florence Hillebrand  
 (ADDRESS) \_\_\_\_\_  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Herrman DATE 6/9/40  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. ...  
 20. FILED 6-8 1940 Anna K. Riehoff  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 7, 1940  
 22. I HEREBY CERTIFY That I attended deceased from Mar 1, 1940 to June 7, 1940  
 I last saw him alive on June 7, 1940. Death is said to have occurred on the date stated above, at 8:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Impairment of Left Foot  
Septicemia  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Senility, Hypertension  
 Name of operation Removal of Tarsal Bones  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no 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 no  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Howard Horkman, M. D.  
274 (Address) Herrman Mo.

**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 myself  
....., Registered Apprentice No.....

working under my personal supervision.

Signed H. P. Lending

Licensed Embalmer No. 2044

P. O. Address Hermon, Me

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21703  
Registrar's No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 303

Primary Registration District No. 4182

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD—  
HOWENA MOORE

1. PLACE OF DEATH:

(a) County Barren  
(b) City or town Hermann  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barren  
(c) City or town Hermann Mo.  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

John F Hillebrand

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 5 2 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month June day 7  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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

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?  
(Specify type of place) \_\_\_\_\_  
While at work? (Specify means of injury) \_\_\_\_\_

23. Signature Howard Harkness (M. D. or other) \_\_\_\_\_  
Address Hermann Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **21703**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **303**

Primary Registration District No. **4182**

Registrar's No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Wassonade**  
(b) City or town **Hermann**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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)

3. (a) PRINT FULL NAME **John F. Hillebrand**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **76** Months **5** Days **2** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month **June** Day **7**  
Year **1946** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death **Banergene**

**left foot**

Due to **Septicemia**

Due to **Corn Salve Used on Corn**

**little toe**

Other conditions **Senility Hypertension**

(Include pregnancy within 3 months of death)

Major findings: **Banergene foot Pericostitis**

Of operations: **sloughing of soft tissue**

Of autopsy. **g. g. a.**

Duration **7**  
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 **Howard Harkman**

Address **Hermann** Date signed \_\_\_\_\_

SUPPLEMENTARY