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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27235

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7134

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2614a Howard Street.
(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 _____
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 2614a Howard Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life _____ years.

3. (a) PRINT FULL NAME SARAH HILDERBRAND. 436

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Michael Hilderbrand 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased December 13, 1867.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 8 9 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name Dont know

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

14. Maiden name Dont know

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

16. (a) Informant Mr. Wilfred Hilderbrand.
(b) Address 5323 Sutherland Ave.

17. (a) Burial (b) Date thereof 8-24-1940.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.

(b) Address 5966-68 Easton Ave.

19. (a) AUG 23 1940 (b) J.F. Buddeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd.
year 1940 hour 7 minute 40 P.M.

21. I hereby certify that I attended the deceased from Aug 11 1940 to Aug 22 1940
that I last saw her alive on Aug 22 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Pan. Neoplasm with Arterio-Sclerosis

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Physician's signature: [Signature]
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?
While at work? _____ (Specify type of place) _____
Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address 4901st Easton Date signed 8/23/40

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

MOTHER FATHER

Dr. A. F. Henke.
4901 Eastern Ave.

Form 3921, 1 to 2:30 P.M.

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 3454
David C. Gibson, Registered Apprentice No. _____
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

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.