

LED APR 19 1943  
Registration District No. 818

Primary Registration District No. 1

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

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: Deaconess Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 days  
(Specify whether \* years, months or days)

3. (a) PRINT FULL NAME WALTER E. BILHORN.

3. (b) If veteran, name war none.

3. (c) Social Security No. 492-05-2696

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

6. (b) Name of husband or wife Myrtle M. Bilhorn. 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased August 12, 1891.  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51.</u>	<u>7.</u>	<u>23.</u>	hr. min.

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

10. Usual occupation Engineer & Contractor

11. Industry or business Bilhorn, Bowers & Peters

12. Name Christien F. Bilhorn.

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

14. Maiden name Josephine Lauchner.

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

16. (a) Informant Mrs Myrtle M. Bilhorn.

(b) Address #44 Crestwood Drive.

17. (a) Cremation. (b) Date thereof 4/7/43.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Crematory.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) APR 7 1943 (b) J. F. Budeck  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis,

(c) City or town Clayton  
(If outside city or town limits, write "RURAL")

(d) Street No. #44 Crestwood, Dr., 2 R.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th  
year 1943 hour 8 minute 05 A.M.

21. I hereby certify that I attended the deceased from April 4 1943 to April 5, 1943  
that I last saw him alive on April 5, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Infarct of left lung about 1 hour

Due to A. Mural Thrombus resulting from a myocardial infarct 9 days

Due to Coronary Thrombosis 9 days

Other conditions (include pregnancy within 3 months of death) nc.

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

Of autopsy Pulmonary Infarct of left lung  
Mural Thrombus Myocardial Infarct.  
Coronary Thrombosis

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 David M. Skilling, Jr. (M. D. or other) M.D.  
Address 4500 Olive Street Date signed 4-5-43

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. David H. Skilling.  
4500 Olive, St.,  
FO-3800  
Hrs. 2 to 4 P.M.

2288

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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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City - D

**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, fact should be so stated above.**