

FILED DEC. 3 1949
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2408 Rochester
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **35 Yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **2408 Rochester**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Emil Hilbert**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, widower **2 divorced Widower**

6. (b) Name of husband or wife **Josephine Hilbert** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug. 7 1869**
(Month) (Day) (Year)

8. AGE: Years **74** Months **3** Days **15** If less than one day hr. _____ min. _____

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

10. Usual occupation **Blacksmith**

11. Industry or business _____

MOTHER FATHER { 12. Name **No Record**
13. Birthplace **Austria**
(City, town, or county) (State or foreign country)
14. Maiden name **no record**
15. Birthplace **Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **John Fattor**

(b) Address **2408 Rochester**

17. (a) **Burial** (b) Date thereof **Nov 24 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn**

19. (a) **11-23-43** (b) **D. C. Brown**
(Date received local register) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV.** day **22**
year **1943** hour **5** minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____;
Deputy to **Coroner**
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Arteriosclerotic heart

Due to _____
Disease

Due to _____
93d

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

Major findings:
Of operations _____
Of autopsy **Inspection History**

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? _____

While at work? _____ (Specify type of place)
(b) Means of injury _____
23. Signature **C. E. Forster** (M.D. or other) **17 7-10**
Address **23 Mc Coy** Date **11/23/43**

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 *me*

....., Registered Apprentice No.
working under my personal supervision.

Signed *C. H. Wise*

Licensed Embalmer No. *2570*

P. O. Address *PO 2nd*

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.