

**FILED MAR 27 1944**

Registration District No. **18**

Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 mo., 22 days  
(Specify whether  
 In this community 20 years  
years, months or days)

3. (a) PRINT FULL NAME Ethel Hilliard

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

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

6. (b) Name of husband or wife Tom Hilliard 6. (c) Age of husband or wife if alive 55 years

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

8. AGE: Years Abt. 46 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business No. 10

12. Name Unknown  
 13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown  
 15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Hilliard  
 (b) Address 3112 Brantner

17. (a) Burial (b) Date thereof 3 15 44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director A. L. Seal Und.  
 (b) Address 2726 Lucas Ave.

19. (a) MAR 14 1944 J. F. Budesh  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 100  
 (c) City or town St. Louis, 17  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3112a Brantner Pl.  
(If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March day 10,  
 year 1944 hour 11 minute 01 P. M.

21. I hereby certify that I attended the deceased from January  
17, 1944 to March 10, 1944;  
 that I last saw her alive on March 10, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage with Hemiplegia Duration 2 months

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_

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

23. Signature Alva Moore (M. D. or other) \_\_\_\_\_  
 Address 2601 White Date signed 3/13/44

**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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4219<sup>th</sup> E. Garfield

**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.**