

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26855  
State File No. 4021  
Registrar's No. 3346

FILED AUG 23 1944

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3829 TROOST AVENUE 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 6 YRS. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3829 TROOST AVENUE 3  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ANNE HELENE HILDEBRAND

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 Andrew Hildebrand 6. (c) Age of husband or wife if alive widowed

7. Birth date of deceased FEB. 27 1859 (Month) (Day) (Year)

8. AGE: Years 85 Months 5 Days 16/15 If less than one day hr. min.

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

10. Usual occupation NONE

11. Industry or business AT HOME

12. Name NELS NELSON

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

14. Maiden name UNKNOWN

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

16. (a) Informant MRS. IRMA ORTH

(b) Address 3829 TROOST

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 15 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Oconomowoc, Wisconsin

18. (a) Signature of funeral director D.W. Newcomer, Sons

(b) Address 1401 Brush Creek, K.C. Mo.

19. (a) 8-14-44 (Date received local Registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 12 year 1944 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 23 1943 to Dec 12 1944 that I last saw her alive on Dec 12 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration  
Due to Senility

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93 d

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? \_\_\_\_\_

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

23. Signature Dr. Henry (M. D.) Date signed 8/14/44  
Address 814 Professional Bldg

Duration

2 Mo

85

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Mr. Oscar P. ...  
814 ...  
3-5 Pm ...

**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 Oscar Hartney

Licensed Embalmer No. 1767

P. O. Address 110 Mo

**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.