

Registration District No. _____ Primary Registration District No. _____

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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 19 days
(Specify whether _____)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 809 N. 12th St.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Frank Hillebrand
 3. (b) If veteran, name war None
 3. (c) Social Security No. 491-05-7404

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Katherine Hillebrand
 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased October 11 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 25 hr. _____ min.

9. Birthplace Saline County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk
 11. Industry or business McKinley Hotel

MOTHER FATHER
 12. Name Joseph Hillebrand
 13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
 14. Maiden name Josephine Heinzler
 15. Birthplace Frankfort Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katherine Hillebrand
 (b) Address Kansas City, Mo.

17. (a) Burial (b) Date thereof 9-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
 (b) Address 4700 Washington Blvd.

19. (a) SEP 7 1944 (b) J. J. Breda
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6th
 year 1944 hour 9 minute 00 P. M.
 21. I hereby certify that I attended the deceased from 8/28/44
 _____, 19____, to Sept. 6th, 1944.
 that I last saw him alive on Sept. 6th, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Atherosclerotic Heart Disease
 Due to _____
 Due to _____
 Other conditions 9/3
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 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)
 (e) Means of injury 0

23. Signature K.B. Schlademan (M. 8/18/44)
 Address 1515 Lafayette Date signed _____

Duration _____
PHYSICIAN

 Underline the cause to which death should be charged statistically.

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

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 *W. Wilkins*
Licensed Embalmer No. *3578*

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, fact should be so stated above.