

Registration District No. 317

Primary Registration District No. 3069

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Max Allen Hill

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

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

6. (b) Name of husband or wife Crystal Hill
6. (c) Age of husband or wife if alive..... 35 years

7. Birth date of deceased December 29 1902
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 5 6 hr. min.

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

10. Usual occupation Filling Station Operator

11. Industry or business

MOTHER FATHER { 12. Name John Hill
13. Birthplace Robinson Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Mattie Titess
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Crystal Hill
(b) Address Robinson, Ill.

17. (a) Removal (b) Date thereof 6-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 6 1945 (b) E. E. McBurnham M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Crawford
(c) City or town Robinson
(If outside city or town limits, write "RURAL")
(d) Street No.....
(If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5
year 1945 hour 10:35 minute A. M.

21. I hereby certify that I attended the deceased from June 2
1945, to June 5 1945
that I last saw him alive on June 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Vaso-motor Collapse
Due to Generalized Toxemia
Due to 200a

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....
Of autopsy Nothing gross found except lung and spleen enlarged

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 M. D. Hoppe (M. D. or other) M.D.
Address 5400 Arsenal St. Date signed 6/5/45

Duration
6/4/45
6/2/45
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

16
9
3

MAR 13 1959

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.....

J. W. Wilkins

Licensed Embalmer No.....

3570

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.