S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 23 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22990

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2869

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: RESEARCH HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7-6-45-7-8-45 (Specify whether
In this community 50 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON Co

(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 4225 CLARK STREET
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country --

3. (a) PRINT FULL NAME DR FRED. E HILDEBRAND

3. (b) If veteran, name war No

3. (c) Social Security No. 708-18-8476

4. Sex MALE 0

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. CECELIA HILDEBRAND

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased NOV (Month) 1 (Day) 1888 (Year)

8. AGE: Years 56 Months 8 Days 7 If less than one day ___ hr. ___ min.

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

10. Usual occupation OPTOMETRIST

11. Industry or business

FATHER
12. Name EMIL O. HILDEBRAND
13. Birthplace (City, town, or county) RUSSIA 6 (State or foreign country)

MOTHER
14. Maiden name LILLIAN KEITH
15. Birthplace XENIA (City, town, or county) OHIO 1 (State or foreign country)

16. (a) Informant MRS CECELIA HILDEBRAND

(b) Address 4245 CLARK ST.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation MT. MORIAH CEM

18. (a) Signature of funeral director W. H. Newcomer's Sons

(b) Address 1401-BRUSH CREEK BLVD.

19. (a) 7-9-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 8th year 1945 hour 3 minute 45 P M.

21. I hereby certify that I attended the deceased from May 12, 1945, to July 8, 1945 that I last saw him alive on July 8, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acute pulmonary edema	1 da
Due to Left Lobar pneumonia	4 da
Due to	2 MO
Other conditions angina pectoris (Include pregnancy within 3 months of death)	[illegible]

Major findings:
Of operations
Of autopsy 108

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address 820 Prof Bldg Date signed 7/9/45

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(Licensed Embalmer's Statement on Reverse Side)

820. Professional Bldg
1912; 24

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 E. Oscar Forney

Licensed Embalmer No. 1967

P. O. Address Kansas City

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.