

V. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29701**
3824
Registrar's No. **3824**

Registration District No. **149**

Primary Registration District No. **1002**

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

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: General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-DAYS
(Specify whether years, months or days)

In this community 30 YEARS

3. (a) PRINT FULL NAME Anna Hildebrand

3. (b) If veteran, name war No

3. (c) Social Security No. NO ONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. WALTER HILDEBRAND

6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased: APRIL 18 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>4</u>	<u>26</u>	hr. min.

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

10. Usual occupation AT HOME

11. Industry or business

MOTHER FATHER

12. Name UNKNOWN VALENTINE

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

14. Maiden name SOPHRONIA COLEMAN

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

16. (a) Informant Mrs. J. Hildebrand

(b) Address P.O. Box, Kansas

17. (a) CREMATION (b) Date thereof SEPT-15-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

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

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 9-15-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

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. 1005 Locust
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 14
year 1945 hour 8 minute 01 A.M.

21. I hereby certify that I attended the deceased from September 12, 1945 to September 14, 1945
that I last saw her alive on September 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death brain hemorrhage

Due to

Due to

Other conditions 83a
(Include pregnancy within 3 months of death)

Major findings:
Of operations see above

Of autopsy see above

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 Wm W. ... (other)
Address Act. Med. Dir. K.C. General Hospital
Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Edward Northey

Licensed Embalmer No. 1167

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.