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43  
5-17-39  
X35897

STANDARD CERTIFICATE OF DEATH

Registration District No. 318

Primary Registration District No. 1003

State File No. 31974  
Registrar's No. 8877

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3732 Page Blvd., /  
(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 Amelia R. Hillstrom

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

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

6. (b) Name of husband or wife Court Hillstrom and of wife if Court Hillstrom alive \_\_\_\_\_ years

7. Birth date of deceased. April 1 1887  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
58 6 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Phillip Michel,  
13. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)  
14. Maiden name Marie Stender,  
15. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Court Hillstrom,  
(b) Address 3732 Page Blvd.,

17. (a) Burial (b) Date thereof 10-16-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director John P. Collins, Inc.  
(b) Address 928 N. Grand Blvd.,

19. (a) OCT 15 1945 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-00  
(c) City or town St. Louis, Mo. 17  
(If outside city or town limits write "RURAL")  
(d) Street No. 3732 Page Blvd., 911  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th  
year 1945 hour 4 minute 15 P. M.

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

Immediate cause of death. Coronary occlusion 2hrs  
Due to Nephrosclerosis ?  
arteriosclerosis 5 yrs

Other conditions. (Include pregnancy within 3 months of death) 12/1

Major findings: Of operations none  
Of autopsy none

Duration  
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? \_\_\_\_\_

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

23. Signature W. J. Verda (M. D. or other) \_\_\_\_\_  
Address Water Bldg. Date signed 10-15-45

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 *Robert W. Kasper*

Licensed Embalmer No. *1861*

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.**

Registration District No. 318

Primary Registration District No. 1003

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(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

Amelia R. Hillston

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 58

Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county)

(State or foreign country) Ill

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name: \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) OCT 30 1945 (Date received local registrar)

(b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Date signed \_\_\_\_\_

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

SUPPLEMENTARY

31974