

FILED DEC 24 1946

State File No. _____

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 142

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

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 weeks
(Specify whether years, months or days)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME FRANK HILDERDIAND

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Elizabeth Quinn Hilderdiand

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Feb. 23 1864
(Month) (Day) (Year)

8. AGE: Years 82 Months 9 Days 12 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John Hilderdiand

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

14. Maiden name Victoria

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

16. (a) Informant Mrs. Garland Salmon

(b) Address Franklin, Mo. R#1

17. (a) Removal (b) Date thereof 12-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Holst. Cent. (Morgue)

18. (a) Signature of funeral director C. S. Newman

(b) Address New Franklin Mo.

19. (a) 12-14-46 (b) DeHopper
(Date received local registrar) (Registrar signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard

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

(d) Street No. R.R. 1, Franklin Mo
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 5
year 1946 hour 11 minute 30 a.M.

21. I hereby certify that I attended the deceased from Sept 9, 1946 to Dec 5, 1946
that I last saw him alive on Dec 5, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema
Emphysematous bullae
Due to asthma

Due to _____

Other conditions myocarditis unknown
(Include pregnancy within 3 months of death)

Major findings: 93E
Of operations _____

Of autopsy Emphysematous bullae

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 G. F. Chamberlain (M. D. or other) _____
Address New Franklin Mo Date signed 12-9-46

Duration

3 years
3 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-21-46

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

R. L. Hall

Licensed Embalmer No.

3515

P. O. Address

New Franklin Mo

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.