

No. 2
12-45
17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31792
Registrar's No. 246

Registration District No. 200
Primary Registration District No. 5725

1. PLACE OF DEATH:
(a) County Macon
(b) City or town rural Hudson
(c) Name of hospital or institution: St. Helene Sanatorium
(d) Length of stay: In hospital or institution June 26-1947
In this community to Sept 17-1947

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Andrew
(c) City or town Rural
(d) Street No. R1 Benton City Mo
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME John J. Hildebrand
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 17
year 1947 hour 5 minute 35 P.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
(b) Name of husband or wife _____ (c) Age of husband or wife if alive 1859 years

21. I hereby certify that I attended the deceased from June 26, 1947, to Sept 17, 1947
that I last saw him alive on Sept 16, 1947
and that death occurred on the date and hour stated above.

7. Birth date of deceased Oct 16 1859
(Month) (Day) (Year)

Immediate cause of death Chronic Myocarditis and cerebral arteriosclerosis
Due to arteriosclerosis 3 yrs

8. AGE: Years 87 Months 16 Days 1
If less than one day _____ hr. _____ min.

Due to _____
Other conditions (include pregnancy within 5 months of death) _____

9. Birthplace Montgomery Co Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Retired farmer
11. Industry or business _____
12. Name John H. Hildebrand
13. Birthplace Switzerland
(City, town, or county) (State or foreign country)
14. Maiden name Louisa Kellendals
15. Birthplace unknown
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant John H. Hildebrand
(b) Address Benton City Mo
17. (a) removal (b) Date thereof Sept 18-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Benton City Mo
18. (a) Signature of funeral director Robert S. Keener
(b) Address Macon Mo
19. (a) 10/20/47 (b) Cluth McNeely
(Date received local registrar) (Registrar's signature)

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 2
23. Signature W. H. Boyd D.O. (M. D. or other) _____
Address Macon Date signed Sept 17, 47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10
District File Number 10-47-1408

OCT 13 1947

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

Howard E. Myers

Registered Apprentice No.

768

working under my personal supervision.

Signed

Albert Skinner

Licensed Embalmer No.

31

P. O. Address

Mecon

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. eur

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 246

1. PLACE OF DEATH:

(a) County macou

(b) City or town equal

(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 _____ (Specify whether _____)

years, months or days

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 _____

3. (a) PRINT FULL NAME John J. Hildebrand

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife no record. 6. (c) Age of husband or wife if _____

7. Birth date of deceased oct 16 1907

(Month) (Day) (Year)

8. AGE: Years 87 Months _____ Days _____ (less than one day)

hr. _____ min.

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Jan year 1947 hour _____ minute _____ M.

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

Immediate cause of death _____

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) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-3179Z