. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 3 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35842

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9719

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. John's Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4-weeks (Specify whether years, months or days)
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 3689a Olive St. (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) 19 0
If yes, name country

3. (a) PRINT FULL NAME Margaret G. Hild
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F. 1
5. Color or race W.
6. (a) Single, widowed, married, divorced M. 1
6. (b) Name of husband or wife Peter Hild
6. (c) Age of husband or wife if alive 67 years
7. Birth date of deceased Sept. 18th., 1881 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	1	0	hr. min.

9. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation At Home
11. Industry or business
MOTHER FATHER
12. Name William McBride
13. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
14. Maiden name Mary Thompson
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Mr. Peter Hild
(b) Address 3689a Olive St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-47 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.
19. (a) OCT 20 1947 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 18th., year 1947 hour 8 minute 30 p. M.
21. I hereby certify that I attended the deceased from Oct 8th, 19 47 to Oct 18 19 47
that I last saw h. alive on Oct 18 19 47
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Vascular Accident (Type undetermined)	
Due to Arteriosclerosis, Generalized	
Due to	
Other conditions Pneumonia, bronchial (Include pregnancy within 3 months of death)	
Major findings: Of operation Cause of abscess not known	
Partial autopsy (no head)	
Of autopsy Bronchial pneumonia + infra hepatic abscess	

PHYSICIAN — Underline the cause of 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 0
23. Signature W. C. Massey (M. D. or other) M.D.
Address 634 No Euclid Date signed 10/19/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.