

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County.....
 (b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **DePaul Hospital**
(If not in hospital or institution, write street number and location)
 (d) Length of stay: In hospital or institution **2 months**
(Specify whether years, months or days)
 In this community **20 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Frank T. Hillstead**
 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 **M.**
 6. (b) Name of husband or wife **Norma Phyllis Payne**
 6. (c) Age of husband or wife if alive **6** years
 7. Birth date of deceased **4/6/1904**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	44	2	12	br. min.

9. Birthplace **Granite City, Ills.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Shipping Clerk**
 11. Industry or business **Malencroft Chemical Co.**
 12. Name **Ross Hillstead**
 13. Birthplace **Norway**
 14. Maiden name **Stella Johnson**
 15. Birthplace **LeRoy, Ills.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Stella Johnson**
 (b) Address **5964 Oakhurst**
 17. (a) **Burial** (b) Date thereof **6-21-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Lake Charles Alexander Home**
 18. (a) Signature of funeral director **Alexander Home**
 (b) Address **6175 Delmar**
 19. (a) (Date received local registrar) **JUN 21 1948**
 (b) **J. J. Breese** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **St. Louis**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5964 Oakhurst**
(If rural, give location)
 (e) Citizen of foreign country?.....
 If yes, name country.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **June** day **18**
 year **1948** hour **1:00** minute **00** P.^{M.}

21. I hereby certify that I attended the deceased from **April 26** 19**48** to **June 18** 19**48**
 that I last saw him alive on **June 18** 19**48**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhagic Gastro Enteritis**
 Due to **?**
 Other conditions **Purulent Cholecystitis**
(include pregnancy within 3 months of death)

Major findings: **Dilatation of small intestines & ileus**
 Of autopsy: **Hemorrhage into intestines**

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..... (e) Means of injury.....
 23. Signature **John A. Hagedorn** (M. D.)
 Address **607 N. Grand St** Date signed **6-19-48**

Duration
 PHYSICIAN
 Underline the cause of which death should be charged statistically.

J. L. A.

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 *Thomas R. Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *6175 Delmar*

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.