

FILED JUN 29 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21257**  
Registrar's No. **5588**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis, Mo.</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>Marissa</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Louis Children's Hosp.</b>                  |  | d. STREET ADDRESS (If rural, give location)<br><b>8</b>                                |  |

|  |                                   |  |  |
|--|-----------------------------------|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Carolyn</b>   | b. (Middle) <b>Sue</b>            | c. (Last) <b>Hilderbrand</b>   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>June 19-51</b>   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Never Married</b> | 8. DATE OF BIRTH<br><b>May 25-51</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br><b>Sparta, Ill.</b>               | 9. AGE (If years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 1 WEEK Hours Mins.<br><b>25</b> |

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>Robert F. Hilderbrand</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Flora Iwiese</b> | 14. NAME OF HUSBAND OR WIFE<br><b>None</b> |
|--|--|--|

|   |  |   |         |
|---|--|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Robert F. Hilderbrand</b> | ADDRESS |
|---|--|---|---------|

|   |   |                |  |
|---|---|----------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Meningitis, type undetermined</b>   |                | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Congenital hydrocephalus</b><br>DUE TO (c) <b>Congenital</b> |                | <b>23 days</b>                                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Congenital Bilateral Cataracts</b>   |   | <b>23 days</b> |  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|   |  |  |
|---|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR<br><b>752X</b> |
|---|--|--|

22. I hereby certify that I attended the deceased from **6-19-1951** to **6-19-1951**, that I last saw the deceased alive on **6-19-1951**, and that death occurred at **7:20 p.m.**, from the causes and on the date stated above.

|   |                   |   |                                    |
|---|-------------------|---|------------------------------------|
| 23a. SIGNATURE<br><b>Dr. L. Shusterman M.D.</b> | (Degree or title) | 23b. ADDRESS<br><b>Children's Hosp.</b> | 23c. DATE SIGNED<br><b>6-19-51</b> |
|---|-------------------|---|------------------------------------|

|   |                             |  |   |
|---|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24b. DATE<br><b>6-20-51</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Odd Fellows</b> | 24d. LOCATION (City, town, or county) (State)<br><b>Percy, Ill.</b> |
|---|-----------------------------|--|---|

|  |  |  |   |
|--|--|--|---|
| DATE REC'D BY LOCAL REG.<br><b>JUN 20 1951</b> | REGISTRAR'S SIGNATURE<br><b>J. B. Foster</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Albert H. Hoppe</b> | ADDRESS<br><b>4700 Washington Blvd.</b> |
|--|--|--|---|

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 Me

working under my personal supervision.

Student Embalmer No.....

Signed Elton H. Remelux

Signed.....  
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.