

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

34520

State File No.

FILED OCT 9 - 1953

BIRTH NO.		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>247</u>		Registrar's No. <u>2488</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. LENGTH OF STAY (in this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Granite City</u>		<u>8/20</u> <u>8</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2807 Palmer</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>HARRY</u>		b. (Middle) <u>EDWARD</u>		c. (Last) <u>HILL</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 18, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Iron worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		9. AGE (in years last birthday) <u>53</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 19, 1953</u>	
11. BIRTHPLACE (State or foreign country) <u>Fulton, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Frank Hill</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Spoon</u>		14. NAME OF HUSBAND OR WIFE <u>Leona Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>338-10-4292</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Leona Hill Granite City, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>ASHD</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Month</u> <u>4200</u>			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1, 1953</u> , to <u>Sept 19, 1953</u> , that I last saw the deceased alive on <u>Sept 19, 1953</u> , and that death occurred at <u>3:42 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Dr. C. MacDonald M.D.</u>		23b. ADDRESS <u>539 N. Grand</u>		23c. DATE SIGNED <u>9-21-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>9-22-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9/22/53</u>		REGISTRAR'S SIGNATURE <u>Hebert J. Sommers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Sedlak</u>		ADDRESS <u>Granite City, Ill.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 17 1987

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

Student Embalmer No.

Licensed Embalmer No. 3747

P. O. Address Medicine, Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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