

FILED SEP 16 1954

STANDARD CERTIFICATE OF DEATH

31880

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7750

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. CITY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John's Hospital.</u>		d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐	
e. LENGTH OF STAY (In this place) <u>5 days</u>		e. STREET ADDRESS (If rural, give location) <u>4935 Leahy Avenue.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u> b. (Middle) <u>HILL</u> c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>August 19, 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 5, 1905</u>
9. AGE (In years last birthday) <u>49</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Patterson Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jesse Booher</u>		13b. MOTHER'S MAIDEN NAME <u>Harriett Ray</u>	
14. NAME OF HUSBAND OR WIFE <u>Stephen D. Hill</u>			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>489-10-3569</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Stephen D. Hill, 4935 Leahy Avenue.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain tumor? Left motor area & right hemiplegia</u>	
		INTERVAL BETWEEN ONSET AND DEATH <u>Severe</u>	
		1941	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES ☐ NO ☒			
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21b. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21d. HOW DID INJURY OCCUR? <u>237X</u>	

22. I hereby certify that I attended the deceased from Aug 14, 1954, to Aug 19, 1954, that I last saw the deceased alive on Aug 19, 1954, and that death occurred at 10 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>John J. Hammond</u> (Degree or title) _____		23b. ADDRESS <u>634 N. Grand</u>	
23c. DATE SIGNED <u>8/21/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Aug 23, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Bonne Terre Missouri.</u>

DATE REC'D BY LOCAL <u>AUG 23 1954</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Shepard Funeral Home, 1167 Hamilton Ave.</u>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

3197

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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 410
P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.