

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28797**

BIRTH NO. _____ REG. DIST. NO. **370** PRIMARY REG. DIST. NO. **6255** Registrar's No. **39**

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY WAYNE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY ST LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give town) RURAL COWEN (township) | | c. CITY OR TOWN ST LOUIS | |
| c. LENGTH OF STAY (in this place) | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | f. STREET ADDRESS (If rural, give location) 3853 OLIVE ST. 211 | |

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 3. NAME OF DECEASED (Type or Print) a. (First) FRED b. (Middle) _____ c. (Last) HILTERBRANT | | 4. DATE OF DEATH (Month) 9 (Day) 6 (Year) 55 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED DIVORCED | 8. DATE OF BIRTH OCT. 6, 1900 |
| 9. AGE (In years last birthday) 54 | | 10. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR | | 10b. KIND OF BUSINESS OR INDUSTRY BUILDING | |
| 11. BIRTHPLACE (City and State or Foreign Country) JEFFERSON CO. MO | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME WILLIAM HILTERBRANT | | 13b. MOTHER'S MAIDEN NAME SUSAN Mc DONALD | | 14. NAME OF HUSBAND OR WIFE JUANITA HILTERBRANT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME ANNA RADER ADDRESS 3521 CHOUTEAU ST. LOUIS | |

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|---|--|--|--|--|--|
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) DROWNING | | INTERVAL BETWEEN ONSET AND DEATH 1 MIN. | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (b) _____ | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | DUE TO (c) _____ | | | |

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|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 9298 | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE RENDING (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) CASTOR RIVER | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) COWEN TOWNSHIP WAYNE MO. | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 6 1955 7 P.M. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? SWIMMING | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7 P.M.**, from the causes and on the date stated above.

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|--|--|--|--|---|--|
| 23a. SIGNATURE Mervin Bowles (Type or title) | | 23b. ADDRESS 321 NORTH MAIN ST. LOUIS MO. | | 23c. DATE SIGNED Aug 8 55 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 8-10-55 | | 24c. NAME OF CEMETERY OR CREMATORY ST MATTHEWS CGM | |
| 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO. | | DATE REC'D BY LOCAL REG. Aug 10 1955 | | REGISTRAR'S SIGNATURE Bretta Ward ADDRESS 495 | |
| FUNERAL DIRECTOR'S SIGNATURE Norman W. Kish | | ADDRESS Piedmont MO. | | | |

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

AUG 11 1955
WAYNE CO. HEALTH CENTER
FILE NO.

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

Student Signed Marion E. Bowler
Signature of Student Embalmer

Licensed Embalmer No. 414
P. O. Address Redford

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.