

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3043

State File No. ....

499

FILED FEB 14 1958

BIRTH NO. ....

REG. DIST. NO. ....

318

PRIMARY REG. DIST. NO. ....

1003

Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Ann 4071</b>	d. Is residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <b>1 Day</b>		e. STREET ADDRESS (If rural, give location) <b>3132a Joachim</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Children's Hosp</b>		27	
3. NAME OF DECEASED a. (First) <b>Carol</b> b. (Middle) <b>Ann</b> c. (Last) <b>Hilton</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-13-58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>4-29-43</b>
9. AGE (In years last birthday) <b>15</b>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Willard Ray Hilton</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Gatlin</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Jane Mansfield</b>		ADDRESS <b>500 S. Kingshighway</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>OK</b>	
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <b>John 2/17/58</b>	
19a. DATE OF OPERATION <b>7-1-58</b>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		592X	
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) (Minute)	
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 <b>1-12</b> , 19 <b>58</b> , to <b>1-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-13</b> , 19 <b>58</b> , and that death occurred at <b>4:15 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Don L. Thurston</b> (Degree or title) <b>MD</b>		23b. ADDRESS <b>Children's Hospital</b>	
23c. DATE SIGNED <b>JAN 15 '58</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>1/14/58</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Collier Mortuary, St. Ann, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JAN 15 58</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</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, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Sheldon Collier*.....

Licensed Embalmer No. *338*.....

P. O. Address *St. Ann*.....

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.