

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030517
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8085

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
FULL NAME OF (If NOT in hospital, give location) 28 HOSPITAL OR INSTITUTION Malcolm Bliss Hosp.		d. STREET ADDRESS (If outside, give location) 2849 5446 Neosho St.	
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD H. L. HILL		4. DATE OF DEATH Month Day Year Aug. 18, 1958	
5. SEX male ☒	6. COLOR OR RACE white	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH July 22, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY R.L. Polk Directory	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Henry W. Hill		13b. MOTHER'S MAIDEN NAME Emma K. Meyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes; no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492-24-4796H	
17. INFORMANT Mr. Aug. A. Schwendener		Address 6024 Highfield Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Encephalomalacia of the Brain</i> DUE TO (b) <i>Coronary insufficiency</i> DUE TO (c) <i>Shock Therapy</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Follow-up injury occurred while receiving treatment at City Hospital #1, on August 18th, 1958 at 9:10 am.</i>			INTERVAL BETWEEN ONSET AND DEATH 955X 46
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 23 Shop	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 9:10 8 18 58		20f. CITY, TOWN OR LOCATION St. Louis Mo	
21. I attended the deceased from Death occurred at 9:10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) James M. Kelly, M.D. 3	
22b. ADDRESS 1300 Clark		22c. DATE SIGNED 8-20-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Aug. 22, 1958	
23c. NAME OF CEMETERY OR CREMATORY St. Matthew Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave		25. DATE RECD. BY LOCAL REG. AUG 20 58	
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Carroll

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 *Home H. Fritz*

Licensed Embalmer No. *3882*
P. O. Address *St. Louis*

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.