

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019250
STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. 5272

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-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION HOMER G. Phillips		Length of stay in lb	d. STREET ADDRESS 4548 ENIGHT (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle william Last Hilliard			4. DATE OF DEATH Month 5 Day 30 Year 59
5. SEX MALE	6. COLOR OR RACE Colonel	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 22 1900
9. AGE (In years at birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MERIDIAN, MISS
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Robert F. Hilliard	
13b. MOTHER'S MAIDEN NAME MINIE		14. NAME OF HUSBAND OR WIFE DANELLA Hilliard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes April 1, 1918 - July 4, 1919		16. SOCIAL SECURITY NO.	17. INFORMANT Address DANELLA Hilliard 4548 ENIGHT
18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrasis of Liver Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Dehydration DUE TO (c) 581.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John M. Fisher		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 6/2/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-4-59	23c. NAME OF CEMETERY OR CREMATORY NATIONAL Cemetery	23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS, MO
24. FUNERAL DIRECTOR MRS. S. J. WATSON 2769 Phooters		25. DATE RECD. BY LOCAL REG. JUN 2 59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ester K. Harris*

Licensed Embalmer No. *4458*

P. O. Address *4181 Wash*

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.