

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>5074a Page</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JULIA</u> Middle Last <u>HILL</u>			4. DATE OF DEATH Month <u>August</u> Day <u>11th</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-71</u>	9. AGE (last birthday) <u>89 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formerly: housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>ADAM SCHALTER Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown Rasina Simon</u>		14. NAME OF HUSBAND OR WIFE <u>John Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>JULIUS SCHALTER o'Fallon, Ill.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Degenerative &amp; arteriosclerotic heart disease</u>		
DUE TO (b) <u>Generalized arteriosclerosis</u>		
DUE TO (c) <u>Senescence</u>		<u>4221F</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>subcapital fracture of rt femur Surgically treated 3-25-60</u> <u>wound infection and decubitus. (2-27-60) with post-operative</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Slipped &amp; fell to floor</u>	
20c. TIME OF INJURY Hour <u>!</u> Month, Day, Year a.m. p.m. <u>2-27-60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>St. Louis State Hospital</u>	20f. CITY TOWN, OR LOCATION COUNTY STATE <u>St. Louis, Mo.</u>
21. I attended the deceased from <u>August 1, 1924</u> to <u>Aug. 11, 1960</u> and last saw her <sup>her</sup> alive on <u>Aug. 11, 1960</u> Death occurred at <u>7:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. <u>L. Hofstatter, M.D.</u>			
22a. SIGNATURE <u>L. Hofstatter M.D.</u>	22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>8-12-60</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-12-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>SHiloh ILLINOIS</u>
24. FUNERAL DIRECTOR <u>Wohfersberg</u>	ADDRESS <u>O'Fallon, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 12 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*ok gmm  
P. 8-12-60*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Frank Probst

Licensed Embalmer No. 4356

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.