

FILED JUL 26 1961

318

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6638

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>9 days</b>		c. CITY OR TOWN <b>Jennings</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5337 College Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>W.</b> Last <b>Hillinghorst</b>				4. DATE OF DEATH Month <b>7</b> Day <b>14</b> Year <b>61</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/16/96</b>	9. AGE (last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serviceman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Typewriter Repair</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Wm. Hillinghorst</b>			13b. MOTHER'S MAIDEN NAME <b>Anne (unknown)</b>			14. NAME OF HUSBAND OR WIFE <b>Mildred Hillinghorst</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Roy Hillinghorst, Ft. Lauderdale</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema Fla. 2 days</b> DUE TO (b) <b>Cardiac Decompensation 7 weeks</b> DUE TO (c) <b>Metastatic Adenocarcinoma ?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I <b>? Premature lesion Metastatic</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.) <b>164x</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <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 <b>11-17-58</b> to <b>7-14-61</b> and last saw him alive on <b>7/14/61</b> Death occurred at <b>1:40</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>3800 N. Kuyperway Mo. St. Louis</b>		22c. DATE SIGNED <b>7/15/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>7/17/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis County Mo.</b>				
24. FUNERAL DIRECTOR <b>Drehmann-Harral</b>			ADDRESS <b>1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 17 1961</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

Dr. Jos. E. Cacloppo  
3400 N. Kingshighway  
Ev. 1-6667

Hrs. 10-12 noon Sat.

### 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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address \_\_\_\_\_

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.