

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

31-21379 AMENDED

IC 20 706 639 318

Primary Registration District No. 1003

Registrar's No. 11355

-61-042508 STATE FILE NUMBER

FILED DEC 12 1961

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) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 2 DAYS	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NO. GRAND AVE.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2847A PESTALOZZI Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last EDWARD B HILLEBRAND			4. DATE OF DEATH Month Day Year 12/4/61	
---	--	--	---	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/17/88	9. AGE (last birthday) 73	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) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	-----------------------------------	---	---------------------------------------

13a. FATHER'S NAME FRANK HILLEBRAND	13b. MOTHER'S MAIDEN NAME ELIZABETH ATHERN	14. NAME OF HUSBAND OR WIFE -----
--	---	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I	17. INFORMANT MATHILDA DELBRUEGGE (NIECE)	Address 4041 FAIRVIEW ST. LOUIS, MO.
--	--	---

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) RUPTURE OF AORTIC ANEURYSM		
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE AND HYPERTENSION		
DUE TO (c) 4200		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 checked="" type="checkbox"/> NO <input 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.)
---	---	--

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 VA	COUNTY	STATE
---	--	--	------------------------------------	--------	-------

21. I attended the deceased from 12/2/61 to 12/4/61 and last saw him alive on 12/4/61 Death occurred at 12:35 PM m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE CONSTANCIO P. TIGLAD	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 12/4/61
--	-------------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC 9 1961	23c. NAME OF CEMETERY OR CREMATORY NEW PICKER CEM.	23d. LOCATION (City, town, or county) ST. LOUIS	(State) MO.
---	-------------------------	---	--	----------------

24. GENERAL DIRECTOR Thomas Katis 2906 Gravoie	25. DATE RECD. BY LOCAL REG. DEC 6 1961	26. REGISTRAR'S SIGNATURE Karl Smith, M.D.
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 grove

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.