1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

33443

State File No.

Registration District No. 784 — Primary Registration District No. 101 — Registrar's No. 1609

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days) In this community life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Glencoe (If outside city or town limits, write "RURAL")

(d) Street No. Manchester Rd. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Glen Hilliard 463

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex male | 5. Color or race white | 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 20 (Day) 1939 (Year)

8. AGE: Years | Months 1 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Clayton (City, town, or county) Mo. (State or foreign country)

10. Usual occupation nil.

11. Industry or business

FATHER
12. Name Russell Hilliard
13. Birthplace ..... (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Nellie Stromp (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature Gellie Hilliard
(b) Address Glencoe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-39 (Month) (Day) (Year)
(c) Place: burial or cremation Bethel Cem-Pond, Mo

18. (a) Signature of funeral director Geo. Schrader
(b) Address Ballwin, Mo.

19. (a) SEP 8 1939 (Date received local registrar) (b) R Meyer MD DPH (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 8 year 1939 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from 9/5/39, 19..., to 9/8/39, 19...; that I last saw him alive on 9/8/39, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
1. Diarrhea	13 days
2. Malnutrition	" "
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Curtis Sauer (M. D. or other) M.D.
Address St. Louis County Hospital Date signed 9-8-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Theo. Schrader

Licensed Embalmer No. 3066

P. O. Address Ballwin, Mo

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33443
Do not use this space.

1. PLACE OF DEATH
(a) County St Louis — Registration District No. 784
(b) Township — Primary Registration District No. 101 — Registered No. 1609
(c) City Clayton — (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Glen Hilliard
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-20 1939
7. AGE — YEARS: — MONTHS: 1 — DAYS: 19 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED 9-8, 1939 T R Meyer M D D P H
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept Aug - 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9/5, 1939, to 9/8, 1939
I last saw him alive on 9/8, 1939. Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Curtis Sauer, M. D.
(Address) St Louis Co Hosp.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.