

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.

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

Do not use this space.

SEP 25 1934

31531

1. PLACE OF DEATH

County St. Louis Registration District No. 1120  
Township Cassville Primary Registration District No. 02480  
City Richmond (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward)

File No. \_\_\_\_\_  
Registered No. 317

2. FULL NAME

(a) Residence No. 909 O'Fallon St. St. Louis, Mo. Ward. St. Louis, Mo.  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) no record of birth

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
about 23

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, 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) Mississippi

13. NAME Hubbards

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

15. MAIDEN NAME Hubbards

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

17. INFORMANT Robert Koch Hosp. Record  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE 8-29 1934

19. UNDERTAKER A Russell and Co.  
(ADDRESS) 2732 Pine St.

20. FILED 8-29 1934 Rob H. Tate Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-27 1934

22. I HEREBY CERTIFY, That I attended deceased from 7-14 1934, to 8-27 1934

I last saw him alive on 8-27 1934 Death is said

to have occurred on the date stated above, at 6:50 a.m.

The principal cause of death and related causes of importance were as follows:

Pulmonary tuberculosis

23A 23

23B 20

23C 20

Other contributory causes of importance: 27

Pulmonary tuberculosis of 1st clinical period

multiple tuberculous abscesses

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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) Melvin Jess M. D.

(Address) Koch Hosp, Koch Mo

