

No. 2
-11-10-39
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13458

State File No.

Registrar's No.

3660

Registration District No.

Primary Registration District No.

791

1003

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Days
(Specify whether
In this community
years, months or days)

8. (a) PRINT FULL NAME Mary Hutton 350

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

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife William Hutton 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased 5/2/1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 20 If less than one day
hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name John Harris

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Jane

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jennie Berle

(b) Address 1204a Monroe Ave.

17. (a) Burial (b) Date thereof 4-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Sullivan

(b) Address 2849 N. Euclid

19. (a) APR 23 1940
(Date received local health officer's certificate) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2816 N. Florissant
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22,
year 1940 hour 10:30 minute A. M.

21. I hereby certify that I attended the deceased from April 18, 1940 to April 22, 1940;
that I last saw her alive on April 22, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pellagra
Syphilis (aortic)
valvular insufficiency

Due to.....
Due to.....

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy None

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?

While at work?.....
(Specify type of place) (e) Means of injury.....
23. Signature A. Lawrence (M. D. or other)
Address 1515 Lafayette 10/22/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Albert Mayfield

Licensed Embalmer No.

3077

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