

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

Do not use this space.  
**15550**

**15281**

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis* (No. *City Infirmary*)

Registration District No. **791**  
Primary Registration District No. **1003**

File No. ....  
Registered No. **4494**  
St. .... Ward)

**2. FULL NAME**

*Harry Hues*

(a) Residence. No. *Infirmary, St. Louis* Ward **13**  
(Usual place of abode)

Length of residence in city or town where death occurred **17** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 12, 1864*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>64</i>	<i>1</i>	<i>12</i>	<i>12</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *nil*  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Minnesota*  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *August Hues*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Pa.*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Barbara Kuhn*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

14. INFORMANT *Mrs. M. Effinger*  
(Address) *Infirmary*

15. FILED **APR 25 1923** *Star C Starling*  
19... REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 24* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *2/27/27* 19... to *4/24* 19... 19... that I last saw him... alive on *4/21* 19... and that death occurred, on the date stated above, at *10 p.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Ch. Myocarditis*

CONTRIBUTORY (SECONDARY) *Ch. Nephritis*  
*10* (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *R. Berg*, M. D.  
(Signed) (Address) *800 Arsenal St.*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

*Mountantah City* *Apr 26 1928*

20. UNDERTAKER *A. L. Moll* ADDRESS *Mountantah Ill*

WRITE PAINLY, WITH UNFADING INK---THIS IS 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.

