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

Do not use this space.

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 25705

Township ..... Primary Registration District No. 1098 Registered No. 7523

City St. Louis (No. En Route to City Hosp #1 ..... St. ..... Ward)

2. FULL NAME Raphael G. Hine

(a) Residence. No. 7567 Harter Place St., 23 Ward. St. Louis Co. 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: 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: Ethel Hine

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: Abt 38 — YEARS: 38 — MONTHS: ✓ — DAYS: ✓ — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): International Hosp. Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Willis G. Hine
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Iowa
12. MAIDEN NAME OF MOTHER: Mary Gregory
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky

14. INFORMANT: F. H. Maughmer
(Address): St. Joseph Mo.

15. FILED 21 1923 Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 20 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic

93E Myocarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemer, ~~M.D.~~

7/21, 1928 (Address) Def. Coroner

*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: St. Joseph Mo. — DATE OF BURIAL: 7/22 1928

20. UNDERTAKER: Southern U. & T. Co. — ADDRESS: 7315 S. Bdway

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.

...INK—THIS IS A PERMANENT RECORD