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

Do not use this space

12874

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital #2 ..... St. ..... Ward)

File No. 3424

Registered No. .....

2. FULL NAME Wm. Hill

(a) Residence. No. 1405 N. 8th St., 25 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 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: Col.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

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

7. AGE: abt. 49 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

PARENTS

10. NAME OF FATHER Wm. Hill
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pa.
12. MAIDEN NAME OF MOTHER Molly West
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Miss

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED MAR 17 1929 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-6- 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-3-, 1929, to 3-6-, 1929 that I last saw him alive on 13-6-, 1929, and that death occurred, on the date stated above, at 4:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
107A
(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (SECONDARY) 1 EON
(duration) ..... yrs. ..... mos. ..... ds.

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? X ray
(Signed) J. E. Cunningham, M. D.
, 19 (Address) 2945 Sarton

*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: Washington U.
DATE OF BURIAL: 3-13 1929

20. UNDERTAKER: Walter Richter
ADDRESS: 3500 Rutger St.

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.

237

2 22 22