

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

Do not use this space.

31872

PLACE OF DEATH

County St. Louis
Township Central
City University City (No. 6814 Corbitt)

Registration District No. 1160
Primary Registration District No. 4470

File No. 88
Registered No. _____
St. _____ Ward _____

2. FULL NAME Thomas J. Hurst
Residence No. 6814 Corbitt St. Ward _____
(Usual place of abode) (if nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 7 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) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19, 1850

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
	78	10	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician

(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) Tenn

10. NAME OF FATHER Henly Hurst

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER Cecelia Stone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.

14. INFORMANT J. J. Hurst
(Address) 6214 Corbitt Ave

15. FILED 9-9-29 Virginia Tuschek
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/8 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1928 to Sept 25 1929
that I last saw him alive on Sept 8 1929, and that death occurred, on the date stated above, at 10 39 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocardial insufficiency
12A
97
16 1/2 (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Stenosis aortic atherosclerosis
(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? physical
(Signed) John H. Ritter, M. D.

9/9 1929 (Address) 6500 Maple
*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 West Frankfort **DATE OF BURIAL** 9-11-29
UNDERTAKER Holland & Kull Co. **ADDRESS** Frankfort

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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