

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

Do not use this space.

38916

791

1003

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City *St. Louis* (No. *City Hospital*)

File No.....

Registered No. *11390*

St..... Ward)

2. FULL NAME

(a) Residence. No. *1522 1/2 Spring* Ward.....

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Widowed*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 60

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *at Home*
(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) *Ireland*

10. NAME OF FATHER *Richard M. Donough*

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

12. MAIDEN NAME OF MOTHER *Ann Sabert*

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

14. INFORMANT (Address) *City Hospital*

15. FILED *NOV 20 1929* *Max J. Stanley* REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 19 1929*

17. HEREBY CERTIFY That I attended deceased from *Nov 14 1929* to *Nov 19 1929* that I last saw him alive on *Jan 19 1929* and that death occurred, on the date stated above, at *6:00 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arthritis deformans
10X Terminal Hypostatic Lobar pneumonia
57.0 (duration) *1* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *101W* (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?
(Signed) *R. Berg* M. D.
11/20 1929 (Address) *City Hospital*

*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 *to abvany* **DATE OF BURIAL** *11-21 1929*

20. UNDERTAKER *Arthur J. Donnelly* **ADDRESS** *2039 Wood 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.

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

15 262

Hutton