

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

Do not use this space.

42036

1. PLACE OF DEATH

County St. Louis Registration District No. 1170
 Township Richmond, Mo. Primary Registration District No. 62487
 City New St. Marys Hospital St. St. Louis Ward 6

File No. _____
 Registered No. 316

2. FULL NAME Victor Hutchinson

(a) Residence. No. 6408 Arthur Ave. St. _____ Ward. St. Louis 6, 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. 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 Anna Hutchinson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 19, 1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	49	7	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Machinist
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer Eagle Laundry Co.

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) New York

PARENTS

10. NAME OF FATHER Michael Hutchinson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. Anna Hutchinson
 (Address) 6408 Arthur Ave.

15. FILED 12/21 19 29 Lo L Jensen
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY. That I attended deceased from 11-10 1929 to 12-19 1929 that I last saw him alive on 12-19 1929, and that death occurred, on the date stated above, at 7:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetic Coma & Cardiac Failure
23A
50 (duration) 5 yrs. 5 mos. 5 ds.
 CONTRIBUTORY Tuberculosis
 (SECONDARY) 7 days @ P.M. (duration) 7 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS V.M.
 (Signed) Victor L. Gould, M. D.

12/19 19 29 (Address) 2759 Sutherland

*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

SS Peter & Paul Dec 23 1929

20. UNDERTAKER Wacker-Helderle ADDRESS 2331 S. Bdwy

PERMANENT RECORD

124 1930
 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County St. Louis Registration District No. 1170 File No.
 Township Primary Registration District No. 6248 Registered No.
 City Richmond High St. Ward)

2. FULL NAME

Victor Hutchinson
 (a) Residence. No. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT
 (Address)

15.

FILED 2/3 1930 Ch. Jensen
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetic Coma
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Tuberculosis of right lung
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS

U. S. B. - Every item of information should be carefully supplied. AGE should be stated FULLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY RECORD

S-42036