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

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.

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. 6815

Township ..... Primary Registration District No. 1003 Registered No. 1651

City St. Louis (No. 4809 Northland Ave. St. ..... Ward)

2. FULL NAME Marie.F.Hughes.

(a) Residence. No. 4809 Northland Ave. St., 6 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug.15.1879

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	50	6	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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

PARENTS

10. NAME OF FATHER James.F.Cullen

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

12. MAIDEN NAME OF MOTHER Elizabeth Moore.

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

14. INFORMANT William A Hughes
(Address) 4809 Northland

15. FILED [illegible] 19[illegible] Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 16 1930

17. No Physician in Attendance
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 10.50 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93C
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 90B
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemer M.D.
2/17, 1930 (Address) Dep. 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 Calvary — DATE OF BURIAL 2-19 1930

20. UNDERTAKER Geo E Mahler 4725 St Louis — ADDRESS