

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

Do not use this space.

10395

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. 3444 Gads Ave. St. Ward)

File No.
 Registered No. 2375
 St. Ward)

2. FULL NAME

Mary Jane Hilliker

(a) Residence, No. 3444 Gads Ave., St., 17 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 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) Nov. 6 - 1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
82 4 0

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) Mo.

10. NAME OF FATHER Ben Johnson

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

12. MAIDEN NAME OF MOTHER Christine Franke

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

14. INFORMANT Frank J. Hilliker

(Address) 3444 Gads Ave.

15. FILED May C. Taylor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 - 1930.

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 6, 1930, that I last saw h. or alive on March 5, 1930, and that death occurred, on the date stated above, at 7: a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
7:00
127th
 (duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic
 (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED at home

IF NOT AT PLACE OF DEATH,
 DID AN OPERATION PRECEDE DEATH? no DATE OF x
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Diagnosis
 (Signed) Karin S. Brookes, M. D.

3/6, 1930. (Address) Gaud Raphaela

*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

Mo. Crematory 3-8-1930

20. UNDERTAKER ADDRESS

Ziegenhein Bro. 2623 Cherokee 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.

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