

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

Do not use this space.

20488

1. PLACE OF DEATH

County St. Louis Registration District No. 784
Township St. Ferdinand Primary Registration District No. 6030
City St. Lo (No. _____) St. _____ Ward _____

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

2. FULL NAME

Thomas A. Hetherington
(a) Residence No. 13 Eden St. Route 17 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. 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) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Elizabeth Hetherington
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17 1860
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 10 16
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Witchman
(c) Name of employer Public Service Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.
10. NAME OF FATHER Thomas Hetherington
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Mary Hoff
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs. Julius Franke
(Address) Garden Station, R. 14
15. FILED 6-7-30 O. A. Schuch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 3 1930
17. I HEREBY CERTIFY, That I attended deceased from January 30, 1930 to June 3, 1930
that I last saw him alive on June 1, 1930, and that death occurred, on the date stated above, at June 3 11 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac Dilatation
93D
953
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (SECONDARY) Myocardia
(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED? POB
IF NOT AT PLACE OF DEATH.
DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Wm. A. Knight, M. D.
6-7-1930 (Address) 8612 N. Hall's Ferry Rd.

*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 Colway Cemetery DATE OF BURIAL June 6 1930
20. UNDERTAKER Fischer & Co. ADDRESS 1732 E. 17th St.

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.

