

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

Do not use this space.

20750  
~~20750~~  
20832

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City St. Louis (No. ....) City Infirmary St. .... Ward) **5631**

**2. FULL NAME** John Hill

(a) Residence. No. 2370 Wash St., 21 Ward. (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 coloured 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) 6-1-1843

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.  
abt. 87 unknown or

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work houseman  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) mo.  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER Ben Hill  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) mo.  
12. MAIDEN NAME OF MOTHER Mrs Sarah Hill  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) mo.

14. INFORMANT M. E. Pideker  
(Address) 5800 Arsenal St.

15. FILED JUN 10 1930 Max E. Stanley REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-4 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-1 1930 to 6-4 1930 that I last saw him alive on 6-3 1930, and that death occurred, on the date stated above, at 400 A. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

131 chronic nephritis  
99 chronic myocarditis  
99 senility  
162 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1290 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) R. K. Ketter M. D.

6-5 1930 (Address) 560 Arsenal

\*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  
Cabary Cemetery 6/10 1930

20. UNDERTAKER ADDRESS  
A. Russell & Co 2732 Pine

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.

