

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

Do not use this space.

28355

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*  
(No. *2749* *Accomac*)

File No.....  
Registered No. *8211*  
St..... Ward.....

**2. FULL NAME**

(a) Residence. No. *2749 Accomac* St., *23* 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 *Female* 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 *Charles W. Hill*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 15 - 1867*

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, ..... hrs. or ..... min.  
*63 5 -*

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) *Cincinnati*  
(STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Jos. Richards*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *P.A.*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *unknown*

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

14. INFORMANT *Charles W. Hill*  
(Address) *2749 Accomac St*

15. FILED *AUG 18 1930* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 15 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 14* 1930, to *Aug 15* 1930 that I last saw *her* alive on *Aug 15* 1930, and that death occurred, on the date stated above, at *9:30 P* m.

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

*822 cerebral hemorrhage*  
*7/401* (duration) ..... yrs. .... mos. *2* ds.  
CONTRIBUTORY (SECONDARY) *arteriosclerosis*  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *NO* DATE OF.....

WAS THERE AN AUTOPSY? *NO*

WHAT TEST CONFIRMED DIAGNOSIS? *Etan*  
(Signed) *H. S. Tyne*, M. D.

*8/16, 1930* (Address) *2757 Accomac*

\*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 *Valhalla Cemetery* DATE OF BURIAL *Aug 18 1930*

20. UNDERTAKER *Pete Brown 3029 Lafayette St* ADDRESS

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.

AV No. 2757

2757-1048

Jan - 1948