

**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. **701**
 Township..... **St. Louis** Primary Registration District No. **10MB**
 City..... **St. Louis** (No. **Christian Hospital**)

29929
 File No.
 Registered No. **8982**
 St. Ward)

2. FULL NAME

John C Mc Hugh
 (a) Residence. No. **4759 Maffitt Ave** St. **6** 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) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 11 1890		
7. AGE YEARS 61	MONTHS —	DAYS 10
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. Day laborer (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) **Massachusetts**

PARENTS	10. NAME OF FATHER Christopher Mc Hugh
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts
	12. MAIDEN NAME OF MOTHER Julia Corney
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Massachusetts

14. INFORMANT **John C Mc Hugh**
 (Address) **4759 Maffitt Ave**

15. FILED **Aug 22 1931**
Max C. Shanker
 REGISTRAR

R MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **8-21 1931**

17. **I HEREBY CERTIFY** That I attended deceased from **8-19 1931** to **8-21 1931** that I last saw him alive on **8-20 1931** and that death occurred, on the date stated above, at **5:50 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Hemorrhage
117B
123B

(duration) yrs. mos. **6** ds.
Ascendental ulcer
 CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. **?** ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF **8-19-31**

WHAT TEST CONFIRMED DIAGNOSIS
Autopsy
 (Signed) **B. M. Blocher**, M. D.
 (Address) **4356 Barne Av**

*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 Cemetery	DATE OF BURIAL Aug. 24 1931
20. UNDERTAKER Arthur J. Donnelly M.D.	ADDRESS 2039 Wash

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.

