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

Do not use this space.

File No. 6559
Registered No. 1631

1. PLACE OF DEATH

County ..... Registration District No. .....
Township ..... Primary Registration District No. .....
City St Louis (No. 2108 Carr St St. ..... Ward)

2. FULL NAME Iotha Hillman

(a) Residence. No. 2108 Carr St., 21 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	Colored	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Oscar Hillman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 1899

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
32	10	1	

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) Aaron, Tenn.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Mack Garin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Thompson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

14. INFORMANT Oscar Hillman
(Address) 2108 Carr St.

15. FILED 19 19 Max C. Farley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 15 1932

17. I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1931, to Feb 15th, 1931 that I last saw her alive on Feb 15th, 1932, and that death occurred, on the date stated above, at 9 25 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
236

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) [illegible]

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Unknown
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical (1)
(Signed) G W Holt, M. D.
, 19 (Address) 932 N. 14th St

*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 Washington Park
DATE OF BURIAL Feb 19 1932

20. UNDERTAKER Wm C. McDowell
ADDRESS 3419 Franklin Ave

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.