

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

Do not use this space.

3207

**1. PLACE OF DEATH**

County..... Registration District No. 485  
 Township..... Primary Registration District No. 1510  
 City St. Louis (No. Seacress Hospital - St. Ward)

File No. ....  
 Registered No. 86

**2. FULL NAME**

(a) Residence, No. 6918 Kingsbury 4 Ward. St. Louis 00, Mo  
 (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<br><u>Female</u>   | 4. COLOR OR RACE<br><u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>Widowed</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Robert P. Hughes</u>              |                                  |   |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 10-- 1958</u>                                      |                                  |   |
| 7. AGE  | YEARS                            | MONTHS  |
|   | <u>74</u>                        | <u>X</u>  |
|   |                                  | <u>21</u>   |
| 8. Trade, profession, or particular kind of work done, as splanner, sawyer, bookkeeper, etc.      |                                  |   |
| 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>at home</u> |                                  |   |
| 10. Data deceased last worked at this occupation (month and year)                                 |                                  | 11. Total time (years) spent in this occupation                             |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Litchfield Illinois</u>                       |                                  |   |
| 13. NAME <u>William Compton</u>   |                                  |   |
| 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>                                   |                                  |   |
| 15. MAIDEN NAME <u>Unknown</u>  |                                  |   |
| 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>UNKNOWN</u>                                   |                                  |   |
| 17. INFORMANT <u>Mrs Mabel A. Ray</u><br>(ADDRESS) <u># 6818 Kingsbury</u>                        |                                  |   |
| 18. BURIAL, CREMATION, OR REMOVAL <u>See</u><br>PLACE <u>Bellefontaine</u> DATE <u>1-4-1933</u>   |                                  |   |
| 19. UNDERTAKER <u>C. P. Lupton &amp; Sons</u><br>(ADDRESS) <u>4479 Olive Street</u>               |                                  |   |
| 20. FILED <u>JAN - 3 1933</u> <u>Max C. Stover</u><br>Registrar.                                  |                                  |   |

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 12 - 1933

22. I HEREBY CERTIFY That I attended deceased from January 10<sup>th</sup>, 1933 to January 12<sup>th</sup>, 1933  
 Last saw h. alive on January 12<sup>th</sup>, 1933. Death is said to have occurred on the date stated above, at 8:15 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Chronic Myocarditis  
Chronic Interstitial Nephritis  
 Date of onset Jan 1932

Other contributory causes of importance:  
None

Name of operation None Date of None  
 What test confirmed diagnosis? Heart bands Was there an autopsy? No  
Biopsy

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? None  
 If so, specify \_\_\_\_\_  
 (Signed) Scott Hayes M.D. M. D.  
 (Address) 1106 No 8th St, Saint Louis, Mo.

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.

Mo. Theatre Bldg.