DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 13

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38352

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 10191

1. PLACE OF DEATH:

(a) County St. Louis, Mo. 1

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Infirmary Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution March 30, 1939. (Specify whether
In this community 20 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Mo. (b) County ~~St. Louis.~~

(c) City or town St. Louis, Mo. 13
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? American. years.

3. (a) PRINT FULL NAME Raymond McHugh, 220

3. (b) If veteran, name war No.

3. (c) Social Security No. NONE

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Doris Cook

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February (Month) 15 (Day) 1903 (Year)

8. AGE: Years 36 Months 9 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace FOLEY (City, town, or county) MO. (State or foreign country)

10. Usual occupation Chauffeur.

11. Industry or business X 0

FATHER
12. Name Walter McHugh 9
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Manta Broyles
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature O. Mahony
(b) Address 5800 Arsenal St.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/30/39 (Month) (Day) (Year)
(c) Place: burial or cremation Foley, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) NOV 29 1939 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27, year 1939. hour 6:35 minute p. M.

21. I hereby certify that I attended the deceased from March 30, 1939, to November 27, 1939 that I last saw him alive on November 27, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Parkinson's Disease

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence None
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Geo. S. Bozalis M.D. (M. D. or other)
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Rev. 5-17-39 1 X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.