

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33758

State File No.

Registrar's No.

8455

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 16 1940

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: DePaul Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Bridget Hughes

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Michael Hughes 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 4, 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER { 12. Name Terrance Hoben

FATHER { 13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Tierney

15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Shien

(b) Address 4253 No 21 Str

17. (a) Burial (b) Date thereof 10/12/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 2117 E. Grand Blvd.

19. (a) OCT 11 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limit, write "RURAL")  
(d) Street No. 4253 No. 21 Str  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? 55 Years. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10  
year 1940 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 7, 1940, to Oct. 10, 1940  
that I last saw her alive on Oct. 9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Decompensation Unknown

Due to: Chronic Degenerative Myocarditis

Due to: \_\_\_\_\_  
Other conditions: 131  
(Include pregnancy within 3 months of death)

Major findings: Of operations: \_\_\_\_\_  
Of autopsy: 1. Fatty degenerative myocarditis  
2. Arteriosclerotic hypertension

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(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? \_\_\_\_\_

23. Signature Charles W. Wilson (M. D. or other) \_\_\_\_\_  
Address 3911 Lee Ave. Date signed 10/11/40

Chas Martin  
3911 Lee  
11 AM

**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 Frank A. Moore

Licensed Embalmer No. 3041

P. O. Address 2117 E. Grand

**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.