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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1944

Registration District No. 318

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 467

Registrar's No. 1143

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: St John Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Week in Hospital (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 009 17 23

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

(d) Street No. 2105 B S Jefferson Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME MAYME HUGHES

3. (b) If veteran, name war

3. (c) Social Security No. 498-05-2264

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Michael Hughes

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

7. Birth date of deceased JUNE (Month) 14 (Day) 1886 (Year)

8. AGE: Years 57 Months 7 Days 20 If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Seamstress

11. Industry or business

FATHER
12. Name JOHN DECKER
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Ida EDMONDS
15. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

16. (a) Informant's own signature ELTON MANLEY
(b) Address 3007 A Park Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1944 (Month) (Day) (Year)
(c) Place: burial or cremation St Mathews Cem

18. (a) Signature of funeral director [signature]
(b) Address 2906 Gravois Ave.

19. (a) FEB 4 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3 year 1944 hour 5 30 A.M. minute M.

21. I hereby certify that I attended the deceased from Jan 24th, 1944, to Feb 3, 1944; that I last saw her alive on Feb 3, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Rt upper & left lower

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Humboldt Bldg Date signed 2-4-44

(Licensed Embalmer's Statement on Reverse Side)

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.....David Van Forman.

Licensed Embalmer No.....4242.

P. O. Address.....2906 Harris

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

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