V. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 12 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29109

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8536

1. PLACE OF DEATH:

(a) County

(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: Barnes Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23/4 hrs. (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson 50

(c) City or town Festus 3 (If outside city or town limits, write "RURAL")

(d) Street No. 123 Frisco St. N.R. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Roy Lee Hughes

3. (b) If veteran, name war Nil

3. (c) Social Security No. 498-12-2000

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 24 (Day) 1884 (Year)

8. AGE: Years 61 Months 6 Days 4 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Levi Hughes
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Mary F. Ray
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Hallie Hughes

(b) Address Festus, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington lvd.

19. (a) OCT 2 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 28 year 1945 hour 2 minute 30 a M.

21. I hereby certify that I attended the deceased from 11:45 Pm on September 27, 1945, to 2:30 am on 9-28, 1945, that I last saw him alive on September 28, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Superior mesenteric thrombosis

Due to Auricular Fibrillation.

Due to Arteriosclerotic heart disease

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy As above

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

(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 F R Bradley (M. D. or other)

Address Barnes Hospital, Date signed 9/28

(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.....

Licensed Embalmer No.....

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, fact should be so stated above.