

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

Do not use this space.

6410

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo*

(No. *8121* *Pennsylvania*)

File No.

Registered No. **1511**

St. Ward)

2. FULL NAME

Adam Gayes Layes

(a) Residence. No. *8121 Pennsylvania* St. Ward.

(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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mary Gayes

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 24 1862

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>64</i>	<i>8</i>	<i>28</i>	

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

Day Labor

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Germany -

10. NAME OF FATHER

John Gayes

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Not known

14.

INFORMANT (Address)

Mary Gayes 8121 Pennsylvania

15.

FEB 16 1927 FILED

Max B. Starkeoff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 15th 1927*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 15th 1926* to *Feb 15th 1927* that I last saw him alive on *Feb 12*, 1927, and that death occurred, on the date stated above, at *238 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS

Chronic Parenchymatous Nephritis
131
1927
129 W (duration) yrs. *6* mos. ds.
CONTRIBUTORY (SECONDARY) *arterio Sclerosis*
 (duration) *1* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Joseph Hardy*, M. D.

Feb 15, 1927 (Address) *7602 S. Broadway*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

W. H. Hope *Feb 17 1927*

20. UNDERTAKER

ADDRESS

Funeral Home Co 7849 Mich.

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.

