

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

Do not use this space.

20559

1. PLACE OF DEATH

County Andrew
Township Rochester
City (No. _____) _____

Registration District No. 16
Primary Registration District No. 5020

File No. _____
Registered No. 10
St. _____ Ward _____

2. FULL NAME

Robert Lewis Hayes

(a) Residence. No. _____ 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. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 16 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 2 2

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 _____

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

10. NAME OF FATHER Earl W Hayes

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

12. MAIDEN NAME OF MOTHER Haye Kottach

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

14. INFORMANT Earl W Hayes
(Address) Helena Mo

15. FILED July 18 1927 ms. Bettie Boggs
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1927

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1927, to July 18, 1927, that I last saw him alive on July 17, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

15 4 Premature Birth.
16 (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) 16 (duration) 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) C. M. Reynolds, M. D.
, 19 _____ (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Stor DATE OF BURIAL July 18 1927

20. UNDERTAKER Wm. D. Dutton ADDRESS Union Stor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Cause of death should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

