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

Do not use this space.

25578

File No. .....
Registered No. 17171

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1003
City St. Louis (No. 7145 Alabama Ave. St. ..... Ward)

2. FULL NAME Dorothy May

(a) Residence. No. 7145 Alabama 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-4-27

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			one	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER John May
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Viola Sortieu
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

14. INFORMANT John May
(Address) 7145 Alabama Ave.

15. FILED AUG -8 1927 Max C. Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 5 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1927, to Aug 5, 1927 that I last saw h. alive on Aug 4, 1927, and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
(6 Month Pregnancy)
154 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) None (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) A. H. Peters, M. D
Aug 8, 1927 (Address) 601 Missouri Bldg

*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 Mt. Olive — DATE OF BURIAL 8/8 1927

20. UNDERTAKER Southern — ADDRESS 7315 S. B'dway

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.

Dr. Peters