

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

Do not use this space.

18366

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Koch

Registration District No. 1123
Primary Registration District No. 6248 B

File No. _____
Registered No. 160
St. _____ Ward _____

2. FULL NAME

Hayes, Lulu

(a) Residence No. 2037 Eugenia St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 1x yrs. 0 mos. 5 ds. How long in U.S., if of foreign birth yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

Single

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
17 Unknown Unknown

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Oliver Hayes
Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14.

INFORMANT R. Koch Hospital
(Address) Koch, Mo.

15.

May 9 19 28 L. C. O'Brook M.D.
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1928

17. I HEREBY CERTIFY, That I attended deceased from May 4 1928 to May 9 1928 that I last saw him alive on May 9 1928 and that death occurred, on the date stated above, at 12:40 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

23A 31
About 31 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray & Sputum
(Signed) W. K. Allen M. D.

5/9/28 (Address) Koch Hospital.

*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 DATE OF BURIAL

Greenwood Cem. 5/13/ 19 28

20. UNDERTAKER

C. H. Pokrto ADDRESS 3035 Lucas Ave.

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.

JUL 29

