

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

Do not use this space.

19435

1. PLACE OF DEATH

County.....
Township.....
City..... (No.....)..... Ward.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **5877**
St..... Ward.....

2. FULL NAME

Radie Hays
(a) Residence. No. **1714 N. Chestnut** St. **11** 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 **Female** 4. COLOR OR RACE **Col** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 25 1865**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
63 4 25

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) **Bonnville Mo**
(STATE OR COUNTRY)

10. NAME OF FATHER **Randolph Hays**

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

12. MAIDEN NAME OF MOTHER **Henrett Nelson**

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

14. INFORMANT **William J. Hays**
(Address) **1924 N. Schiller**

15. JUN - 1 1928 **Max C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25 1928**

17. I HEREBY CERTIFY, That I attended deceased from **Nov 1** 1927 to **May 7** 1928 that I last saw h. alive on **May 7** 1928, and that death occurred, on the date stated above, at **9 P. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

18. WHERE WAS DISEASE CONTRACTED **at home**
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
WAS THERE AN AUTOPSY? **No**
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **Lucretia M. D**
V-28, 1928 (Address) **2335 Franklin**

*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 **Father Dickson** DATE OF BURIAL **June 7 1928**

20. URDERTAKER **A.F. Walton** ADDRESS **2701 Stockland**

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.

