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

Do not use this space.

22174

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

File No. 6352

Registered No. .....

City St Louis Mo. (No. Barnes Hospital St. ..... Ward)

2. FULL NAME Charles Alexander May

(a) Residence. No. 3130 Edgar Pl St., 12 Ward. Maplewood Mo.
(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)
Male.	White	Married.

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Lettie H. May.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 5th 1851.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	76.	6.	9.	

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

9. BIRTHPLACE (CITY OR TOWN) Poland, Ohio
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Daniel May.

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

12. MAIDEN NAME OF MOTHER Unknown, Frankfort, Ky.

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

14. INFORMANT Mrs Lettie H. May.
(Address) #3130 Edgar - Maplewood

15. FILED JUN 15 1928 Mark C. Stanley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6 - 14 1928

17. I HEREBY CERTIFY, That I attended deceased from 5 - 10 - 1928, to 6 - 14 1928, that I last saw him alive on 6 - 14 1928, and that death occurred, on the date stated above, at 3 a. m. 20

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholecystitis, chr 12 A
Cholelithiasis - 9
Myocardial Insufficiency -
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Rupture of Gall Bladder -
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 12 6
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 6-1-28

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? yes

(Signed) Ray E. Newton, M. D
6/15/28 (Address) Barnes 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 Valhalla Cem.

DATE OF BURIAL 6-16-1928.

20. UNDERTAKER E. R. Rupton.

ADDRESS Olive Street #4449

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD