

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

Do not use this space.

/ 12959

1. PLACE OF DEATH

County Registration District No. 701
 Township Primary Registration District No. 1003
 City ST. LOUIS MO (No. 1221) Blair St. Ward

File No.
 Registered No. 3510
 St. Ward

2. FULL NAME

Arcar Hayer Jr

(a) Residence No. 1221 Blair St. 25 Ward. (If nonresident, give city or town and State)
 (Usual place of abode)

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 <u>Male</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct 14, 1927</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>1</u>	<u>15</u>	<u>3</u>	
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				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March, 17th 1929

17. I HEREBY CERTIFY, That I attended deceased from March 17th, 1929, to March 17th, 1929, that I last saw h. alive on March 17th, 1929, and that death occurred, on the date stated above, at 11:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

197A
Bronchial Pneumonia
 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY)
 (duration) yrs. mos. ds.

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

B DID AN OPERATION PRECEDE DEATH? DATE OF

..... WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Jefferson M. D.
March 17th 1929 (Address) 922 N. Jefferson

*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.

9. BIRTHPLACE (CITY OR TOWN) K. C.
 (STATE OR COUNTRY)

10. NAME OF FATHER Arcar Hayer

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

12. MAIDEN NAME OF MOTHER Florida Herron

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

14. INFORMANT Arcar Hayer
 (Address) 1221 Blair

15. FILED 1929 Mar 17 St. Louis
Myrtle Storker
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL
Father Dickson

DATE OF BURIAL
March 21
 1929

20. UNDERTAKER
C. Hevand

ADDRESS
707 N. Leonard

11

11. 11. 11

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Registration District No. 491 File No.
 Township St. Louis Primary Registration District No. 1003 Registered No. 30-10
 City St. Louis (No.) St. Ward)

2. FULL NAME

Oscar Hayer Jr
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE Co 5. SINGLE, MARRIED, WIDOWED OR DIVORCED st
(write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.

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) (STATE OR COUNTRY)

PARENTS
 10. NAME OF FATHER
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address) Gene Parker

15. FILED JUN -6 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Primary information given over
Phone by Dr. J. E. Hurtleir of Wis.
 (duration) 5-21-29 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE.....
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed)....., 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 DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-12959