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

Do not use this space.

14206

File No. .....

Registered No. 3540

1. PLACE OF DEATH

County: St Louis — Registration District No.: 791

Township: ..... — Primary Registration District No.: 1003

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Samuel Hayes.

(a) Residence. No. 4415 Cook Brilliante (Usual place of abode) Ward. ..... (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	Negro.	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): unknown 1874

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt.	55	Unknown	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Hinds County

(STATE OR COUNTRY): Miss

PARENTS

10. NAME OF FATHER: James Toliver

11. BIRTHPLACE OF FATHER (CITY OR TOWN): .....

(STATE OR COUNTRY): Va.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): .....

(STATE OR COUNTRY): Unknown.

14. INFORMANT: Fannie Brazil

(Address) 4415 Cook Brilliante

15. FILED: APR — 9 1930 — Mary C. Tarlton — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4/9 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-2, 1930 to 4-6, 1930 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 7:40 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Apoplexy Cerebral Hemorrhage

131

824

1300

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY) Uremic Poisoning due to Chr. Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? Bed side diagnosis

(Signed) [illegible], M. D.

, 19 (Address) 801a 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Washington Park — DATE OF BURIAL: Apr 9 1930

20. UNDERTAKER: Connett Toney 3436 Lawton — ADDRESS

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

Dr. Walker