

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

Do not use this space.

18031

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **1221**, **Hamilton Ave**) St. Ward

File No.....
 Registered No. **5185**
 St. Ward

2. FULL NAME

John Dayer
 (a) Residence, No. **1221 Hamilton** St., **6** 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 **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 29-1869**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 1 26

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

9. BIRTHPLACE (CITY OR TOWN) **Scotland**
 (STATE OR COUNTRY)

10. NAME OF FATHER **John Dayer**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Scotland**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Margaret Menzies**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Scotland**
 (STATE OR COUNTRY)

14. INFORMANT **Mrs Margaret Duster**
 (Address) **1221 Hamilton**

15. FILED **MAY 27 1930** **Wm C Stabler** REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25 1930**
 17. **Physician in attendance**
 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 **4:00 p.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxiation due to food gas poisoning (self-administered)
1104 C. (duration) yrs. mos. ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
 WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **J. W. Kerner, M.D.**
5/26 1930 (Address) **Def. Coroner**

*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 **St. Peter's Cem** DATE OF BURIAL **May 27 1930**

20. UNDERTAKER **Geo. L. Pleitsch** ADDRESS **5966 East**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important.

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