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

Do not use this space.

25406

1. PLACE OF DEATH

County ——— Registration District No. ..... File No. .....

Township ——— Primary Registration District No. ..... Registered No. 7641

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

2. FULL NAME Raymond Toy

(a) Residence. No. 1206 Goodfellow Av St. 5 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Yellow	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 12 1927

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	2	8	17	

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

9. BIRTHPLACE (CITY OR TOWN) Chicago
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER James K. Lum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) San Francisco
(STATE OR COUNTRY) California
12. MAIDEN NAME OF MOTHER Do Not Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ———
(STATE OR COUNTRY) U. S.

14. INFORMANT Lillie Toy
(Address) 1206 Goodfellow Av

15. FILED 30 1930 Max C. Harvey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1930

17. No 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 1 40 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heat Prostration

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

CONTRIBUTORY (SECONDARY) 194

(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? .....

(Signed) J. W. Kerner M.D.

7/30, 1930 (Address) Dep. Coron

*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
Valhalla Cemetery	July 31st 1930

20. UNDERTAKER	ADDRESS
John P. Collins	928 N. Grand Bl

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.