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

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.

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

2970

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 119

City St Louis (No. Mo. Bapt Hosp. St. ..... Ward)

2. FULL NAME Herbert J. Hays.

(a) Residence. No. 8227 Albin Ave. St., 12 Ward. St. Louis, Co. 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 Magdalena Hays.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22, 1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	40	10	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman 172
(b) General nature of industry, business, or establishment in which employed (or employer) General Machine Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Centralia
(STATE OR COUNTRY) Missouri 1

PARENTS
10. NAME OF FATHER Irvin Hayes.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ?
(STATE OR COUNTRY) Pennsylvania 2
12. MAIDEN NAME OF MOTHER Lola Rodemyre.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Centralia
(STATE OR COUNTRY) Missouri 1

14. INFORMANT Mrs. Magdalena Hays.
(Address) 8227 Albin Ave

15. FILED JAN -5 1931, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1931

17. I HEREBY CERTIFY, That I attended deceased from No Physician in attendance, 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 12.30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Meningitis (Pneumococcic Type)
79B (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 79a (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Wm V Dever ~~M.D.~~ 5
1/5, 1931 (Address) 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	DATE OF BURIAL
Hiram Cemetery	1-5 1931
20. UNDERTAKER	ADDRESS
Geo. L. Pleitsch	5966 Easton Ave.