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

Do not use this space.
11854

791
1003

File No. 3091
Registered No.

1. PLACE OF DEATH

County ..... Registration District No. .....
Township ..... Primary Registration District No. .....
City St. Louis (No. 2808 Dayton St. ..... Ward)

2. FULL NAME Joseph Clay
(a) Residence. No. 2808 Dayton St., 21 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	Col	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1877

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
53		Unknown		

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

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.

PARENTS
10. NAME OF FATHER Felix Clay
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unk Miss.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Miss.

14. INFORMANT Stella Clay
(Address) 2808 Dayton Ave.

15. FILED [illegible] 19 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/7 1931

17. I HEREBY CERTIFY, That I attended deceased from 3/1 1931, to 3/7 1931 that I last saw him alive on 3/7 1931 and that death occurred, on the date stated above, at 6:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Lobnpp
(duration) yrs. mos. 14 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) [illegible] D.
3/10 1931 (Address) 3136 Chouteau

*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
Greenwood Cemetery	3/12 1931
20. UNDERTAKER	ADDRESS
R. M. C. Green	3517 Laclede ave

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 Taylor