

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

Do not use this space.

36420

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

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

13029

2. FULL NAME *Eugene Hayes*

(a) Residence, No. **2013 North St., 9th. Ward. 26**

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

File No.

Registered No. **10959**

St. Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug, 23-1931*

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day,hrs. ormin.
		<i>2</i>	<i>6</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *nil*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) *Saint Louis* (STATE OR COUNTRY) *Missouri*

13. NAME *John Hayes*

14. BIRTHPLACE (CITY OR TOWN) *Missouri* (STATE OR COUNTRY)

15. MAIDEN NAME *Bessie Esmyer*

16. BIRTHPLACE (CITY OR TOWN) *Missouri* (STATE OR COUNTRY)

17. INFORMANT *Keep all information* (ADDRESS) *Gracie St. 1003*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Otosis Mo.* DATE *Oct 31 1931*

19. UNDERTAKER *W. J. Leidner* (ADDRESS) *1417 N. Wood St. St. Louis*

20. FILED **OCT 31 1931** Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 29th. 1931*

22. I HEREBY CERTIFY, That I attended deceased from *Oct. 27th, 1931*, to *Oct. 29th, 1931*

I last saw him alive on *Oct. 29th, 1931* Death is said to have occurred on the date stated above, at *11:00 AM*

The principal cause of death and related causes of importance were as follows:

Transition
158
158
Malnutrition

Name of operation Date of
What test confirmed diagnosis *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify *Jeane Finney* M. D.
(Signed) *City Hospital*
(Address) *City Hospital*

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.

Haley