

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

Do not use this space.

1. PLACE OF DEATH

County Erickson
Township St. Joseph
City St. Joseph (No. 512 So. 21st. St.)

Registration District No. 1001

Primary Registration District No. _____

85

File No. 28561
Registered No. 921
St. _____ Ward _____

2. FULL NAME Rosetta Mays

(a) Residence. No. 512 So. 21st St. St. _____ 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 Female	4. COLOR OR RACE Negro	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12 1932

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>##</u>	<u>2</u>	<u>13</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Robt. Mays Sr.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ga.
(STATE OR COUNTRY) Ga.

12. MAIDEN NAME OF MOTHER Lena Mosley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) South C.
(STATE OR COUNTRY) South C.

14. INFORMANT Robert Mays Sr.
(Address) 512 So. ## 21st. St.

15. SIGNATURE John R. Bender Registrar
File No. SEP 26 1932

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1932

17. Sept. 25 1932

I HEREBY CERTIFY, That I attended deceased from 22 Aug 1932 to 25 Sept 1932
that I last saw him alive on 25 Sept 1932, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sub acute Gastric
enteritis

11 15 (duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (SECONDARY) 119 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chemical

(Signed) [Signature] M. D.

(Address) St. Joseph Mo.

*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 Ashland Cemetery

DATE OF BURIAL Sept. 26 1932

20. UNDERLYING SERVICE 9th & Olive

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.

QCI 24 1932

