

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.

MAR 1 1935

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

Do not use this space.

2614

1. PLACE OF DEATH

County *St. Charles*

Registration District No. *760*

File No. *2*

Township *Wentzville*

Primary Registration District No. *75999*

Registered No. *6*

City *Wentzville*

No. _____

St. _____

Ward _____

2. FULL NAME

Robert Franklin May

(a) Residence, No. _____

St. _____

Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *86 yrs. 10 mos. 19 ds.*

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

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

Marie May

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

March 4-1848

7. AGE

YEARS *86*

MONTHS *10*

DAYS *19*

IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

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

Barber, Retired

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) (STATE OR COUNTRY)

Wentzville Mo

MOTHER FATHER

13. NAME

Charles P. May

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

Rockingham Va

15. MAIDEN NAME

McClary

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

South River Va

17. INFORMANT (ADDRESS)

Wagner May Wentzville Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Wentzville Mo* DATE *1-25 1935*

19. UNDERTAKER (ADDRESS)

J. P. Peterson Wentzville Mo

20. FILED

1-25 1935 McCaldwell Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan 23 1935*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 17 1933* to *Jan 23 1935*

I last saw him alive on *Jan 23 1935*. Death is said to have occurred on the date stated above, at *9:00* a.m.

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

*Chronic Interstitial Nephritis
Mitral Regurgitation (chronic)*

Date of onset *1925*

Other contributory causes of importance:

131

Name of operation *no* Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? *no*

If so, specify _____ (Signed) *V. J. Garinbach*, M. D.

(Address) *Wright Out Mo*

