

JUN 6 1936

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

Do not use this space.

4538

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No. *1804*)

File No. **48341**

Registered No. **4851**

St.

Ward)

2. FULL NAME *Bobie Gay (still born)*

(a) Residence, No. *1804*

St.

Ward. *22*

(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 *Colored*

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 2, 1936*

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, hrs. or min.

OCCUPATION

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

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) *St. Louis Mo.*

13. NAME *Theodore Gay*

FATHER

14. BIRTHPLACE (CITY OR TOWN) *Mo.*

MOTHER

15. MAIDEN NAME *Burlingblay*

16. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo.*

17. INFORMANT *Theodore Gay*

(ADDRESS) *1804*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Washington Park* DATE *May 4, 1936*

19. UNDERTAKER *W.S. Wade and Co.*

(ADDRESS) *4302*

20. FILED *MAY - 4 1936*

Registrar. *J. H. Bredack*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 2, 1936*

22. I HEREBY CERTIFY, That I attended deceased from *May 2, 1936* to *May 2, 1936*

I last saw *the still born baby*, 1936 Death is said

to have occurred on the date stated above, at *2:00 p.m.*

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

Still born

Date of onset *May 2*

Other contributory causes of importance:

A fall on a chair

Name of operation..... Date of..... *No.*

What test confirmed diagnosis? *blinical* 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? *No.*

If so, specify.....

(Signed) *J. A. Flower*, M. D.

(Address) *1711 N. 10th*

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.

