

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.

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

39132  
Do not use this space.

DEC 13 1937

791  
1003

1. PLACE OF DEATH  
 (a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City St. Louis (d) Street No. 2230 McCausland Ave. St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles S. Hayes  
 (a) Residence, No. 2230 McCausland Ave St. 4  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE White  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie May Hayes  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 25, 1872  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
65 6 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Asst. Cashier  
 9. Industry or business in which work was done, as 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) Columbus  
 (STATE OR COUNTRY) Inda

13. NAME William A. Hayes  
 14. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Harriet Kennard  
 16. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Isabel Voorhis  
 (ADDRESS) 5707 McPherson

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Valhalla Cemetery DATE Nov. 1 1937

19. FUNERAL DIRECTOR Jay B. Smith Funeral Home  
 (ADDRESS) 1456 Manchester Ave., Maplewood, Mo.

20. FILED NOV 1 1937  
J. Bredeck  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 29, 1937  
 22. I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1937, to Oct. 29, 1937  
 I last saw him alive on Oct. 29, 1937. Death is said to have occurred on the date stated above, at 2 P.M.

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

Other contributory causes of importance:  
93C

Name of operation ..... 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?  
 If so, specify .....  
 (Signed) F. P. ... M. D.  
 (Address) 607 N. Grand

STATEMENT BY LICENSED EMBALMER

*Howard F Rowland*

Licensed Embalmer No. *3114*

hereby certify that the body recorded on the reverse side of this certificate was embalmed by *myself*.

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed *Howard F Rowland*

Licensed Embalmer No. *3114*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**