

DEC 28 1937

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

42404
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 789
(b) Township Central Normal Primary Registration District No. 60330
(c) City Wellston (d) Street No. 620I Lotus Ave. Registered No. 312
(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.
(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Carl Hayes

(a) Residence, No. 620I Lotus Ave. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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) Sept. 6, 1937.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
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) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Gail Lawrence

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don'T Know

MOTHER 15. MAIDEN NAME Lillian H ayes

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

17. INFORMANT Lillian Hayes
(ADDRESS) 1709 Grove Ave.,

18. BURIAL, CREMATION, OR REMOVAL PLACE Valhalla Cem., DATE Nov. 11/37.

19. FUNERAL DIRECTOR Jos. W. Clark
(ADDRESS) 1125 Hodiament Ave.,

20. FILED 11-11-37 W. B. Beckner
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 10/37. 19

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, 5.05 P.M.

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

Syphilis Date of onset 2 mo.
34

Other contributory causes of importance:

Name of operation None Date of.....
What test confirmed diagnosis? medical 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 John R. Connelley M.D.
(Signed) Korover, St. Louis Co. (Address)

STATEMENT BY LICENSED EMBALMER

I, Jos. W. Clark, Licensed Embalmer No. I66I,

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

L. E.

No. _____ or by _____
working under my personal supervision.

Registered Apprentice No. _____

Signed

Jos. W. Clark

Licensed Embalmer No. I66I

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.)