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.

REC'D AUG 12 1938

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

23435
Do not use this space.

791

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 6129
(c) City Saint Louis (d) Street No. 3951 Fairfax Avenue 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 Infant Hayes 900
(a) Residence, No. 3951 Fairfax Avenue St. 11
(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: Negro
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) July 7, 1938

7. AGE: Stillborn — YEARS / MONTHS / DAYS — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil
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) Saint Louis Missouri 0

FATHER
13. NAME Mark Hayes 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sumner Mississippi 1

MOTHER
15. MAIDEN NAME Dorothy Poston
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saint Louis Mississippi

17. INFORMANT (ADDRESS) Mark Hayes 3951 Fairfax Avenue

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE July 9, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Charles J. Gates 4107 Finney Avenue

20. FILED JUL 9 1938 J. B. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7, 1938

22. I HEREBY CERTIFY, That I attended deceased from 7/6/, 1938, to 7/6/38, 1938
I last saw h..... alive on 7-7, 1938. Death is said to have occurred on the date stated above, at 545 A m.
The principal cause of death and related causes of importance were as follows:

Still Born

Date of onset

Other contributory causes of importance:

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) Wm E. Hill, M. D.
(Address) 1105a North Sarah Street

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, James A. Johnson, or by

Registered Apprentice No. _____, working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

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.)

If this body is not embalmed, above space should be left blank.