

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

Do not use this space.

1. PLACE OF DEATH

County.....  
Township.....  
City St. Louis

Registration District No. 791  
1003  
Primary Registration District No. 791  
(No. Fernie Desloge Hospital)

File No. 30662  
Registered No. 7398  
St. .... Ward)

2. FULL NAME

George William Mayberry  
(a) Residence, No. 3416 Vista ave St. 18 Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 14 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
64 10 17

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

13. NAME Fred Mayberry

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

15. MAIDEN NAME Elizabeth Dalton

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

17. INFORMANT Mrs Minnie Mayberry (ADDRESS) 3416 Vista ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Desloge Mo DATE 9-3-35 19

19. UNDERTAKER Albert H Hoppe (ADDRESS) 429 N Birch St

20. FILED SEP - 12 1935 19 J. Biedick Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-1-35 19

22. I HEREBY CERTIFY, That I attended deceased from 8/28/35 19 to 9/1/35 19.  
I last saw him alive on 9/1/35 19. Death is said to have occurred on the date stated above, at 9:48 a.m.

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

Mural thrombosis (left ventricle) Date of onset  
Left femoral embolism  
Cardiac failure  
Pulmonary edema  
Other contributory causes of importance:  
Generalized atherosclerosis

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) J. J. Dell Vecchio, M. D.  
(Address) Fernie Desloge Hosp

