

1937 SEP 14 1937 91  
Registration District No. 1003

Primary Registration District No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County St. Louis mo  
 (b) City or town St. Louis mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2921 Lawton Ave  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 years, months or days) 25 yrs.

8. (a) PRINT  
FULL NAMEJohn Mayo8. (b) If veteran,  
name warNo8. (c) Social Security  
No.None4. Sex Male5. Color or  
racenegro6. (a) Single, widowed, married,  
divorcedmarried

6. (b) Name of husband or wife

Birdia Mayo6. (c) Age of husband or wife if  
alive54 years

7. Birth date of deceased

Unknown  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

abt 52

hr. min.

9. Birthplace

Ark  
(City, town, or county) (State or foreign country)

10. Usual occupation

COOK

11. Industry or business

Restaurant

MOTHER FATHER

12. Name

William Mayo

13. Birthplace

Ark  
(City, town, or county) (State or foreign country)

14. Maiden name

Unknown

15. Birthplace

Ark  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Birdia Mayo

(b) Address

2921 Lawton17. (a) Washington Park  
(Burial, cremation, or removal)(b) Date thereof 8-26-39  
(Month) (Day) (Year)

(c) Place: burial or cremation

Washington Park

18. (a) Signature of funeral director

W. C. Bro

(b) Address

3646 Finley

19. (a)

AUG 24 1939

(b)

J. J. [Signature]  
(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
 (c) City or town St. Louis, Mo. 21  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2921 Lawton  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 20  
year 1939 hour 3.00 minute P. M.21. I hereby certify that I attended the deceased from 8/7/39  
\_\_\_\_\_, 19\_\_\_\_, to 8/20/39, 19\_\_\_\_;  
that I last saw him alive on 8/20/39, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral hemorrhage Duration1 HDue to Hypertension14 D

Due to \_\_\_\_\_

Other conditions Nephritis  
(Include pregnancy within 3 months of death)2 YRS

Major findings:

Of operations \_\_\_\_\_

None done

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_28. Signature Langston Taylor (M. D. or other)Address 3646 Finley Date signed 8/24/39

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.

**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, or by.....

*Louis V. Atkins*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Louis V. Atkins*

Licensed Embalmer No. *2842*

P. O. Address *3644 Finney*

**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.**