

No. 2  
4-13-40  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27980

SEP 16 1940  
Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 879

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2604 Faraon  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 58 years  
years, months or days)

3. (a) PRINT FULL NAME LUCY FRANCES MAYS 2011  
3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife G.B. Mays 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 15th 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 0 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Plattsburg Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation house work

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James Mathias  
13. Birthplace unknown unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Patsy Hillis  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss ANNA MAYS

(b) Address 2604 Faraon St. Joseph, Mo.

17. (a) burial (b) Date thereof 8-12-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 8/13/40 (b) H.J. Nestlebrush  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2604 Faraon  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 9th.  
year 1940 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 14, 1940, to Aug 9, 1940,  
that I last saw her alive on Aug - 6, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stom.

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

Due to \_\_\_\_\_ 46

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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?  
85

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature H.W. Clark (M. D. or other) me  
Address St. Joseph, Mo. Date signed 8-10-40

Duration  
?   
  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11  
57

**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 me

....., Registered Apprentice No. ....

working under my personal supervision.

Signed Geo E Daniel

Licensed Embalmer No. 3300

P. O. Address St. Joseph Mo

**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, fact should be so stated above.**