

Registration District No. **791** Primary Registration District No. **1003**

**FILED DEC 11 1940**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **Jewish Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 wks** (Specify whether)  
In this community **4 wks.**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **UNIVERSITY CITY NR**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **721 Heman Ave.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **I. McMayer**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **Nov.** day **12**  
year **1940** hour **4** minute **2** M.

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Emma Mayer** 6. (c) Age of husband or wife if alive **54** years  
7. Birth date of deceased **Nov. 8-1878**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Nov. 12, 1940** to **Nov. 12, 1940**  
that I last saw him alive on **Nov. 11, 1940**  
and that death occurred on the date and hour stated above.

8. AGE: Years **62** Months **0** Days **4** If less than one day, hr. min.

Immediate cause of death **Thrombosis** Duration \_\_\_\_\_  
Due to **Left Leg** **6**  
Due to \_\_\_\_\_

9. Birthplace **Columbus Ohio** (City, town, or county) (State or foreign country)  
10. Usual occupation **Prof. of Music**

Other conditions (include pregnancy within 3 months of death) **Senile Atro. Spleen**  
Major findings: Of operation **Left Leg**  
Of autopsy \_\_\_\_\_

MOTHER FATHER { 11. Industry or business **Morris Mayer**  
12. Name **Morris Mayer** **Germany**  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name **Fannie Wise**  
15. Birthplace (City, town, or county) (State or foreign country) **Germany**

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mark Mayer**  
(b) Address **721 Heman Ave.**  
17. (a) **Burial** (b) Date thereof **11-14-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation **Mt. Olive Cemetery**  
18. (a) Signature of funeral director **Herman Rudolph**  
(b) Address **5216 Delmar Blvd.**  
19. (a) **NOV 13 1940** (b) **J. B. Rudolph**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **Ray Sanders** (M. D. or other) \_\_\_\_\_  
Address **12-13-40** Date signed **11-13-40**

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

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

Signed *Chas. W. Cooper*  
Licensed Embalmer No. *3830*  
P. O. Address *5216 Delmar*

**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.**