

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 15 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10008

Registration District No. 17

Primary Registration District No. 4041

Registrar's No. 11

1. PLACE OF DEATH: *Boone Centralia*

(a) County *Boone*

(b) City or town *Centralia*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *1*
(Specify whether)

In this community *1*
years, months or days

3. (a) PRINT FULL NAME *DONALD RAYMOND MAYES*

3. (b) If veteran, name war *-*

3. (c) Social Security No. *-*

4. Sex *MO*

5. Color or race *W*

6. (a) Single, widowed, married, divorced *W*

6. (b) Name of husband or wife *-*

6. (c) Age of husband or wife if alive *8* years (Day) (Year) *1941*

7. Birth date of deceased *Mar 8 1941*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

1 hr. min.

9. Birthplace *Centralia Mo. O*
(City, town, or county) (State or foreign country)

10. Usual occupation *Infant*

11. Industry or business

12. Name *Raymond Mayes*

13. Birthplace *Hollaville RFD Mo. O*
(City, town, or county) (State or foreign country)

14. Maiden name *DOROTHY MAE OGLEVIN*

15. Birthplace *New Bloomfield Mo. O*
(City, town, or county) (State or foreign country)

16. (a) Informant *Raymond Mayes*

(b) Address *Centralia Mo.*

17. (a) *Burial* (b) Date thereof *Mar 10 1941*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Centralia Mo.*

18. (a) Signature of funeral director *[Signature]*

(b) Address *Centralia Mo.*

19. (a) *4-10-1941* (b) *F. H. Borden*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: *10*

(a) State *Missouri* County *Boone*

(c) City or town *Centralia*
(If outside city or town limits, write "RURAL")

(d) Street No. *2*
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Mar* day *9*
year *1941* hour *2:45* minute *P* M.

21. I hereby certify that I attended the deceased from *Mar 8*
8, 19*41*, to *Mar 9 1941*
9, 19*41*
that I last saw him alive on *Mar 9 1941*
and that death occurred on the date and hour stated above.

Immediate cause of death *Brainial pneumonia*

Due to *Cause unknown*

Due to _____

Other conditions *107*
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

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? *36*

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature *[Signature]* (M. D. or other) *118*

Address *Centralia Mo* Date signed *3/9/41*

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

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *M. M. H. H. H.*
Licensed Embalmer No. 2589
P. O. Address *Beulah, 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.