No. 2
-1-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 16 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24234

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2773

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 3600 Lister
(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 40 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 3600 Lister
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME CLINTON T. MAYES

3. (b) If veteran, name war None

3. (c) Social Security No. 487-01-8201

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Grace Mayes

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased June ~~July~~ 29 1890
(Month) (Day) (Year)

8. AGE: Years ~~50~~ 51 Months 0 ~~11~~ Days 24 If less than one day hr. min.

9. Birthplace Joliet (City, town, or county) Illinois 1 (State or foreign country)

10. Usual occupation American Can Co.

11. Industry or business

FATHER
12. Name John T. Mayes
13. Birthplace (City, town, or county) Pa. 1 (State or foreign country)

MOTHER
14. Maiden name Cynthia Thornburg
15. Birthplace (City, town, or county) Illinois 1 (State or foreign country)

16. (a) Informant Grace Mayes
(b) Address 3600 Lister

17. (a) Forest Hill (Burial, cremation, or removal) (b) Date thereof July 26 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill Cem.

18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address 918 Brooklyn

19. (a) 1/24/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1941 hour 12 minute 5 P.M.

21. I hereby certify that I attended the deceased from ..... to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to Mesenteric thrombosis c̄ infarction of the small & large intestine

Due to Ulcerative aortic valvulitis
Luetic aortitis c̄ luetic aortitis valvulitis

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 30D

Of autopsy 30A

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

23. Signature [signature] (M. D. or other) 3
Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. Clair Shippard

Licensed Embalmer No. 4179

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.