

FILED MAY 1943

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 91

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town Bonne Terre Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francis
(c) City or town Flat River Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES T. MAYBERRY

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 2 1943
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 11 hr. _____ min.

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

10. Usual occupation Baby

11. Industry or business _____

12. Name Robert D Mayberry

13. Birthplace Flat River Mo
(City, town, or county) (State or foreign country)

14. Maiden name Chris P. Masdon

15. Birthplace Granite City Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Robert D Mayberry

(b) Address Flat River Mo

17. (a) Burial (b) Date thereof Apr 15 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayberry Cemetery

18. (a) Signature of funeral director C J Boye

(b) Address Peabody Mo

19. (a) April 29 1943 (b) Byndie Bukhmaster
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1943 hour 10 minute _____ P.M.

21. I hereby certify that I attended the deceased from April 12, 1943 to April 13, 1943; that I last saw him alive on April 13, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? None

(e) Means of injury _____ (Specify type of place)

23. Signature W H Cline M.D. (M-D. or other)

Address Flat River, Mo Date signed 4/15/43

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

MOTHER FATHER

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

RECEIVED

District Health Officer No. 4
District File Number 543-214
Date Filed 5-5-43

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 C. Z. Boyer
Licensed Embalmer No. 1671
P. O. Address Wenlock 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.