S. No. 2
M—2-4
5-17-3
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30840

State File No.

Registration District No. 149 Primary Registration District No. 100 Registrar's No.

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: 5439 Garfield Avenue (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---------- (Specify whether years, months or days) In this community 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 2

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 0

(d) Street No. 5439 Garfield Avenue (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Mrs. Jennie S. Mayes

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 John S. Mayes

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

7. Birth date of deceased November (Month) 4 (Day) 1862 (Year)

8. AGE: Years 80 Months 10 Days 19 If less than one day ___ hr. ___ min.

9. Birthplace Shelbyville (City, town, or county) Indiana (State or foreign country)

10. Usual occupation None

11. Industry or business At Home

FATHER
12. Name James S. Lime
13. Birthplace (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Eliza Jane Elden
15. Birthplace (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. J. J. Summers
(b) Address 5439 Garfield

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director D. H. Uncomers Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 9-22-43 (Date received local registrar) (b) T. E. Brown (Registrar's signature) Dep

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21 year 1943 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 20 - 1943, 19__, to Sept 21, 1943 that I last saw her alive on Sept 20, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration 9/6/43

Due to Hypertension and Cerebrovascular disease

Due to

Other conditions (Include pregnancy within 3 months of death) 83d 93d

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Ben H. Brayles (M. D. or other)

Address 1232 Professional Bldg. Date signed 9/22/43

(Licensed Embalmer's Statement on Reverse Side)

1232 Prop. Bldg. 11-1

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address K C 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.