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

DEPARTMENT OF COMMERCE
BUREAU OF CENSUS
1943
FILED OCT 30 1943
Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35768

State File No. _____
Registrar's No. 2409

Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Ballwin
(c) Name of hospital or institution:
Pine Crest Homes
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
In this community UNKNOWN
years, months or days (Specify whether)

3. (a) PRINT FULL NAME George Allen Mays
3. (b) If veteran, name war UNKNOWN
3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Ellen Twilly 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 2 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 7 26 _____ hr. _____ min.

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

10. Usual occupation UNKNOWN

11. Industry or business UNKNOWN

12. Name UNKNOWN Sam Mays

13. Birthplace UNKNOWN TENN
(City, town, or county) (State or foreign country)

14. Maiden name Sally Mitchel

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

16. (a) Informant Mrs P Martin

(b) Address 821 N Kingshighway

17. (a) (Burial, cremation, or removal) BURIAL (b) Date thereof 10/30-43
(Month) (Day) (Year)

(c) Place: burial or cremation LAKE CHARLES, CEM.

18. (a) Signature of funeral director S. Mullaney and Co.
(b) Address 5165 Delmar Bl.

19. (a) OCT 29 1943 (Date received local registrar) (b) E. B. McBarren, Jr. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town 4305 BETHWIN KEDDIAWAY
(If outside city or town limits, write "RURAL")
(d) Street No. V Berta St Louis
(If rural, give location)
(e) Citizen of foreign country? UNKNOWN (Yes or No)
If yes, name country UNKNOWN

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 28 year 1943 hour 10 minute A.M.
21. I hereby certify that I attended the deceased from October 19th, 1943 to Oct 28, 1943
that I last saw him alive on October 27, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration _____

Due to _____
Due to _____
Other conditions Arterio-Sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 43rd
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? _____

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

23. Signature R. H. Jensen (M. D. or _____)
Address Manchester Mo Date signed 10/28/43

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 *H. G. Farris*.....

Licensed Embalmer No. *3384*.....

P. O. Address. *St. Louis*.....

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.