

**FILED SEP 7 1944**  
Registration District No. **149**

Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Bonanza City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5742 Kenwood Avenue  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community 22 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson  
 (c) City or town B  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5742 Kenwood Avenue  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country U

**3. (a) PRINT FULL NAME** Mrs. Josephine Lea Mayes  
 3. (b) If veteran, name war NO 3. (c) Social Security No. none

**MEDICAL CERTIFICATION**  
 20. **DATE OF DEATH:** Month Aug day 15  
 year 1944 hour 8 minute 40 P. M.  
 21. I hereby certify that I attended the deceased from Nov. 10  
 \_\_\_\_\_, 1935, to Aug 15, 1944.  
 that I last saw her alive on Aug 14  
 and that death occurred on the date and both stated above.  
 Immediate cause of death arteriosclerosis  
Senility

4. Sex Female 5. Color or race Whit  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife H. J. Mayes  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased September 1 1857  
(Month) (Day) (Year)

**8. AGE:** Years 92 Months 11 Days 15  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace:** Monticent Missouri  
(City, town, or county) (State or foreign country)

**10. Usual occupation:** none

**11. Industry or business:** at home

**12. Name:** Dr. J. L. Lea

**13. Birthplace:** Denmark  
(City, town, or county) (State or foreign country)

**14. Maiden name:** Harriett Sandy

**15. Birthplace:** Virginia  
(City, town, or county) (State or foreign country)

**16. (a) Informant:** Mrs. P. C. Guthrie

**(b) Address:** 5742 Kenwood Ave

**17. (a) Removal, or removal:** Removal (b) Date thereof: 8-17-44  
(Month) (Day) (Year)

**(c) Place: burial or cremation:** W arenaburg mo

**18. (a) Signature of funeral director:** H. J. Newcomb

**(b) Address:** 1401 Brush Creek Blvd.

**19. (a) Date received local registrar:** 8-16-44 (b) R. E. Brown  
(Date received local registrar) (Registrar's signature)

Due to No particular organ  
Pathologic  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**Major findings:** 97  
 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? \_\_\_\_\_

**23. Signature:** A. E. Siko (M. D. or other) \_\_\_\_\_  
 Address: 243 W. Kirby Bldg Date signed: 8-16-44

Duration 2 yrs  
2 yrs

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

Mr. H. E. Shoen  
Theby Bldg 39<sup>th</sup> Fl  
we 2715

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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 embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**