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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29241

FILED OCT 2 1945

Registration District No. 2186

Primary Registration District No. 1003

Registrar's No. 8381

1. PLACE OF DEATH:

(a) County

(b) City or town ST. Louis, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Isolation Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-4-44 to 9-22-45 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ono

(c) City or town ST. Louis, MO 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal ST. 7 13
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Price Mayhew

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 ? (Month) ? (Day) 1879 (Year)

8. AGE: Years 66 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business None

FATHER
12. Name None
13. Birthplace None (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name None
15. Birthplace None (City, town, or county) 9 (State or foreign country)

16. (a) Informant City Infirmary Records
(b) Address 5800 Arsenal ST.

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 9-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Kuhlen
(b) Address 3500 Rutgers

19. (a) SEP 27 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept, day 22
year 1945 hour 6 minute 30 A M.

21. I hereby certify that I attended the deceased from 10 - 4, 1944 to 9 - 22, 1945
that I last saw him alive on 9 - 22, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-Vascular Disease Arteriosclerosis - Generalized (Indefinite duration) — Duration 1944

Due to

Due to 93d

Other conditions
(Include pregnancy within 3 months of death)

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)

(e) While at work? (e) Means of injury

23. Signature Palmer Bowdish (M. D. or other)

Address 5800 Arsenal Date signed 9-24-45

(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.....

....., 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.

S. P. . 2B
M—8-21-41
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8381

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:

(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Prue Mayhew

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years aft 65 Months Days If less than one day min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct 15 1945 (Date received local registrar) (b) J. F. Buesch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 2 year 1945 hour minute M.

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

Immediate cause of death — *Duration*

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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)

(b) 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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

1945
S-29241