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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40604

FILED JAN 4 8 1946

Registration District No. 1000 Primary Registration District No. 1000 Registrar's No. 1437

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City ~~or town~~ St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 yrs - 0 mo. 5 da. (Specify whether
In this community 5 yrs - 5 da. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 11
(c) City ~~or town~~ Kansas City 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2942 Myrtle 7
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Howard Mayes.

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

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased 7 (Month) 7 (Day) 1892 (Year)

8. AGE: Years 53? Months ? Days ? If less than one day hr. min.

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

10. Usual occupation Railroad Warehouse Trucker

11. Industry or business Railroad.

FATHER
12. Name Edrick Mayes
13. Birthplace unknown (City, town, or county) unknown (State or foreign country)

MOTHER
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant Mrs. Nola Mayes
(b) Address 2942 Myrtle St. K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-46 (Month) (Day) (Year)
(c) Place: burial or cremation State Hosp. Cem.

18. (a) Signature of funeral director Stamey Funeral Home
(b) Address St Joseph Mo.

19. (a) Jan 3-1946 (Date received local registrar) H.J. Westebrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 30 year 1945 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from 3-1- 1943, to 12-29- 1945 that I last saw him alive on 12-29- 1945 and that death occurred on the ~~date~~ and hour stated above.

Immediate cause of death ~~Hypostatic~~ Hypostatic Pneumonia — Duration 4 day

Due to Syphilitic Aortitis — Years

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy yes 3 od

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 0

23. Signature J. H. Morrowey (M. D. ~~or other~~)
Address State Hospital No. 2 Date signed 12/30/45

1428

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

MAR 8 1946

FEB 18 1946

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 John Roy Clancy

Licensed Embalmer No. 2435

P. O. Address St Joseph

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.