

S. No. 2
M-5-43
7-5-17-39
I X38671

FILED JUL 3 1946
Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. 5657

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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000
(c) City or town ST. LOUIS 2111
(If outside city or town limits, write "RURAL")
(d) Street No. 1845 1/2 Otallon St 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) (X)
If yes, name country _____

3. (a) PRINT FULL NAME William Mayfield
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 15 1892
(Month) (Day) (Year)

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

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

10. Usual occupation N.I.

11. Industry or business _____

MOTHER FATHER

12. Name UNKNOWN
13. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)
14. Maiden name Cornelia Smith
15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Shepard 1

(b) Address 2819 Sheridan Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/46
(Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cem.

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St.

19. (a) JUN 27 1946 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1946 hour 2:45 minute P 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 _____
Chronic Interstitial Nephritis
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death) 1/21 a

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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 Thomas F. Callahan (M. D. or other) 1
Address Carner Date signed 6-27-46

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

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 F. Boykin
....., Registered Apprentice No. My
working under my personal supervision.

Signed Fannie Boykin
Licensed Embalmer No. 2946
P. O. Address St. Louis, 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.