

FILED DEC 27 1946

Registration District No. 37Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Lemay
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
DOA St. Louis County Hospital
 (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)

3. (a) PRINT FULL NAME Walter Maynard
 3. (b) If veteran, name war #1
 3. (c) Social Security No. none

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 August 8 1895
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>2</u>	<u>26</u>	hr. _____ min. _____

9. Birthplace East St. Louis, Ill.
 (City, town, or county) (State or foreign country)

10. Usual occupation none
 11. Industry or business none
 12. Name Romas Maynard
 13. Birthplace Ill. unk.
 (City, town, or county) (State or foreign country)
 14. Maiden name Margaret From
 15. Birthplace Europe
 (City, town, or county) (State or foreign country)
 16. (a) Informant Ida Maynard
 (b) Address St. Louis, Mo.
 17. (a) burial (b) Date thereof 12-5-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation National Cemetery
 18. (a) Signature of funeral director Fendler Und. Co.
 (b) Address 7420 Michigan Ave
 19. (a) 12-5-46 (b) Richard Allen M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~XXXXXXX~~ (b) County 999
 (c) City or town Quincy, Illinois
 (If outside city or town limits, write "RURAL")
 (d) Street No. Veterans Hospital
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2
 year 1946 hour 5 minute 55 P.M.
 21. I hereby certify that I attended the deceased from Death without
medical attendance, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Carcinoma of the throat
with exsanguinating hemorrhage

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy No 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?
 While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature Richard Allen M.D. (M. D. or other)
 Address 601 Brentwood Blvd. Date signed 12/4/46

JAN 9 1947

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 *Oliver E. Fendley*
Licensed Embalmer No. *4148*
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.

I