

1. No. 2
-12.45
5-17.39
I X47070

FILED JUN 23 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 752

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1228 So 17 St /

(d) Length of stay: In hospital or institution..... (Specify whether
years, months or days) 3 days

In this community..... (Specify whether
years, months or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

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

(d) Street No. 1228 So 17 St /
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME ROND ELL MAYS

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex male 5. Color or race negro

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: June 6 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>9</u>	hr. min.

9. Birthplace St Joseph, Jackson, Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Robert Mays

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

14. Maiden name May S. Harman

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

16. (a) Informant Robert Mays

(b) Address: 1228 So 17 St, City

17. (a) Burial (b) Date thereof June 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Beatrice May

(b) Address 812 Pacific St

19. (a) 6-17-47 (b) E. L. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1947 hour 8:30 minute A M.

21. I hereby certify that I attended the deceased from
June 7 - 45 to June 16 1947

that I last saw him alive on June 7 - 45 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: I delivered twins June 6 - 1947.

Due to I was called to the home 6/16 - 1947 and baby was dead

Due to I do not know the cause of death.

Other conditions (include pregnancy within 3 months of death)

Major findings:
Of operations 200

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?

While at work? (Specify type of place) (e) Means of injury 0

23. Signature Frederick J. Woodruff (M. D. or other)
Address 108 17th St, St Joseph, Mo Date signed 6/16/47

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.

not embalmed Signed *E. A. ...*
Licensed Embalmer No. *4228*

P. O. Address *St. Joseph 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.