

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **834**

**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: **St. Joseph Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: **1 Day** (Specify whether)  
In this community: **15 Days** (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: **Missouri** (b) County: **Buchanan** //  
(c) City or town: **St. Joseph** //  
(If outside city or town limits, write "RURAL")  
(d) Street No.: **1228 South 17th Street** //  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

**3. (a) PRINT FULL NAME** **King David Mays**

3. (b) If veteran, name war: **No** 3. (c) Social Security No.: **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: **July 16 1948**  
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day  
**0 0 15** hr. min.

9. Birthplace: **St. Joseph Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **Infant**

11. Industry or business: **Infant**

12. Name: **Robert C. Mays**

13. Birthplace: **Columbia County, Georgia**  
(City, town, or county) (State or foreign country)

14. Maiden name: **Mary Gorman**

15. Birthplace: **Elwood, Kansas**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mr. Robert C. Mays**

(b) Address: **1228 South 17th Street**

17. (a) **Burial** (b) Date thereof: **8-2-1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Ashland Cemetery**

18. (a) Signature of funeral director: **Wm. H. Alexander**

(b) Address: **1602 Messanie, St. Joseph, Mo.**

19. (a) **8/1/48** (b) **E. C. Jenkins**  
(Date received local registra- (Regist. signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **August** day **1**  
year **1948** hour **2** minute **10** P.M.

21. I hereby certify that I attended the deceased from **7-24-48**  
....., 19....., to **8-1-**....., 19**48**.  
that I last saw him alive on **8-1-**....., 19**48**.  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Malnutrition** Duration **10 days**

Due to: **Functional Heartbea**

Due to: **10 days prior to death**

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy: **1190**

**PHYSICIAN**

Underline the cause of 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? (c) Means of injury: **0**

23. Signature: **W. E. Greener** (M. D. or other)

Address: **St. Joseph Mo.** Date signed: **8/1/48**

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Wm H Alexander

Licensed Embalmer No. 4450

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.