

S. No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26108
Registrar's No. 21

Registration District No. 144

Primary Registration District No. 5562

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

1. PLACE OF DEATH:
(a) County Iron
(b) City or town Pilot Knob
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community 4 years _____ (Specify whether
years, months or days)

3: (a) PRINT FULL NAME Arthur Mayes
3. (b) If veteran, name war no 3. (c) Social Security No. none
4. Sex 0 male 0 female 0 Color or white
5. Color or white 6. (a) Single, widowed, married, divorced marrie
6. (b) Name of husband or wife Ella Mayes 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased November 2 1902
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
45 8 19 hr. _____ min.

9. Birthplace Iron County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business _____

12. Name James Mayes 9

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

14. Maiden name Elizabeth Liggett (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Ella Mayes

(b) Address Pilot Knob Missouri

17. (a) burial (b) Date thereof 7-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcadia Missouri

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

(b) Address Iron ton Missouri

19. (a) 8-20-48 (b) Arvo Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Iron 47
(c) City or town Pilot Knob 6
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21
year 1948 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from July 8 1948 to July 21 1948
that I last saw him alive on July 21 1948
and that death occurred on the date and hour stated above.

Immediate cause of death acute cardio failure Duration 2-21-48
Due to chronic myocarditis ?
Due to chronic nephritis ?
Other conditions Neuro-psychosis ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 _____

23. Signature R. E. Harland (M. D. or other) M.D.

Address Fronton, Mo. Date signed 8-6-48

RECEIVED

District Health Officer No. 4
District File Number 848-1081
Date Filed 8-30-48

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 Lucy White

Licensed Embalmer No. 2012

P. O. Address Ontario, 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.