

FILED NOV 17 1950
#115058

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38824**
9297

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 26 1514 North 19th Street	
3. NAME OF DECEASED a. (First) SAVANNAH (Type or Print)		b. (Middle) MAYBELLE c. (Last) MAYES	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow 2		8. DATE OF BIRTH Sept. 20, 1891	
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Roselle, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Benjamin Olive	
13b. MOTHER'S MAIDEN NAME Julia Jones		14. NAME OF HUSBAND OR WIFE Andrew J. Mayes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Julia Barton		ADDRESS 2816 Nameoki Road, Granite City, Illinois	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Essential Hypertension ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pericarditis Arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H4AX		22. I hereby certify that I attended the deceased from 9/19/50 , to 10/31/50 , that I last saw the deceased alive on 10/31/50 , and that death occurred at 8:40am m., from the causes and on the date stated above.	
23a. SIGNATURE James A. Hutchinson, M.D.		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 10/31/50		24a. BURIAL, CREMATION, REMOVAL (Specify) removal	
24b. DATE 10-31-50		24c. NAME OF CEMETERY OR CREMATORY Doer Run, Missouri	
24d. LOCATION (City, town, or county) (State) Doer Run, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
25. ADDRESS 4700 Washington		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 1 1950 J. B. Pasater	

WRITE PLAINLY—USING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed W. S. Salfer

Signed.....

Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.