

THE DIVISION OF HEALTH OF THE STATE OF TENNESSEE
STANDARD CERTIFICATE OF DEATH

27420

State File No.

FILED AUG 7-1953

BIRTH NO. _____ REG. DIST. NO. 328 PRIMARY REG. DIST. NO. 3073 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>TENN.</u> b. COUNTY <u>DYER</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHAFFEE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>DYESBURG TENN</u> <u>8410</u>	
c. LENGTH OF STAY (In this place) <u>14 DAYS</u>		d. STREET ADDRESS (If rural, give location) <u>RFD #4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>406 WRIGHT AVE</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>SUSAN</u> b. (Middle) <u>CATHRINE</u> c. (Last) <u>MAYO</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 25 1953</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>4-30-1874</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>25</u>	IF UNDER 12 HRS. Hours <u></u> Mins. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MEDON TENN</u>	12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>
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13a. FATHER'S NAME <u>JOHN STURDIBANT</u>	13b. MOTHER'S MAIDEN NAME <u>LYDIA BRADFORD</u>	14. NAME OF HUSBAND OR WIFE <u>REDMAN M. MAYO</u>
15. HAD DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS

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		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar pneumonia</u>			<u>24 hrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fracture of left Hip</u>			<u>27 days</u>
DUE TO (c) <u>Congestive heart failure</u>		<u>3 yrs ?</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>malnutrition</u>		<u>2 mo. ?</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>841</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 10, 1953, to July 25, 1953, that I last saw the deceased alive on July 25, 1953, and that death occurred at 8:42 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. Schmeyer, D.O. 2</u>	23b. ADDRESS <u>Chaffee, Mo.</u>	23c. DATE SIGNED <u>7/27/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	24b. DATE <u>7-27-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Cape Girardeau Mo</u>
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DATE REC'D BY LOCAL REG. <u>7-28-53</u>	REGISTRAR'S SIGNATURE <u>Mrs F. Braganzhoff</u>	445	24e. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mr. Stubb - Chaffee Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
AUG 3 1953
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 653 - 177

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 _____

..... Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *C. J. Larberg*
Licensed Embalmer No. *3810*
P. O. Address *Cape Girardeau*

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.