

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18307

State File No. ....

4461

FILED MAY 25 1956

318

1003

Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>6638 Bancroft</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>HENRY</b>		b. (Middle) <b>C.</b>		c. (Last) <b>MAYER</b>	
4. DATE OF DEATH		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF DEATH <b>May 6, 1956</b>		9. AGE (In years last birthday) <b>65</b>		10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		11. DATE OF BIRTH <b>July 31, 1890</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Henry Mayer</b>		13b. MOTHER'S MAIDEN NAME <b>Maria Schad</b>		14. NAME OF HUSBAND OR WIFE <b>Edith L. Guels Mayer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>493-10-6574</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Edith L. Mayer, 6638 Bancroft</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>10 years</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>332x</b>		20. AUTOPSY? YES <input checked="" 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) (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>May 3, 1956</b> , to <b>May 6, 1956</b> , that I last saw the deceased alive on <b>May 5, 1956</b> , and that death occurred at <b>1:50 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Marion W. Davis, M.D.</b> (Degree or title)				23b. ADDRESS <b>539 N. Grand</b>		23c. DATE SIGNED <b>5/7/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>May 9, 1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Churchyard</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAY 8 1956</b>		REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>BEIDERWIEDEN F.H., Inc.</b> ADDRESS <b>1936 St. Louis Ave.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

Phone - FR 3-5422  
Hours ~~1:30-3~~ today - Monday

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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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Delis J. Krupin

Licensed Embalmer No. 34

P. O. Address St Paul

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.