

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

334

FILED JAN 28 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 72

STATE FILE NUMBER

1000 72

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hos		d. STREET ADDRESS 204 West Nebraska Ave	
Length of stay in lb 666 yrs.		Reside on Farm <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Goldie Nellie Mayes			4. DATE OF DEATH Month Day Year Jan. 21 1957		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 8, 1895		9. AGE (In years last birthday) 62		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	
13. FATHER'S NAME Charles Harris			14. MOTHER'S MAIDEN NAME Caroline Arnold		
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. None		17. INFORMANT Address James W. Mayes-204 W. Nebraska-City	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, acute</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>331x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>about 6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>previous cerebral thrombosis with hemiplegia in April 1955</u>			

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from <u>8 Jan. 49</u> to <u>1-20-57</u> and last saw her <u>him</u> alive on <u>1-20-57</u> Death occurred at <u>8:50 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thompson E. Potter, M.D.</u>		22b. ADDRESS <u>731 Faron St. St. Joseph, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>	
23b. DATE <u>Jan. 25-'57</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	

24. FUNERAL DIRECTOR ADDRESS <u>Wm. H. Alexander, St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 25, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>	
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Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms must be listed. No symbols will be listed. All names must be in full. No symbols will be listed. All names must be in full. No symbols will be listed. All names must be in full.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Wm H. Alexander*

Licensed Embalmer No. *44*

P. O. Address *57 Jasper*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.