

FILED SEP 30 1957

STANDARD CERTIFICATE OF DEATH

31461

STATE FILE NUMBER

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 918

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Ash Grove 3rd	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle MERLIN Last MAYS		4. DATE OF DEATH Month Sept Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 23-1880
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner of R. M. Map Bell Co.		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 77
10a. FATHER'S NAME E. S. Mays		10b. MOTHER'S MAIDEN NAME Lily Finestone	10c. NAME OF HUSBAND OR WIFE Zella Mays
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		12. SOCIAL SECURITY NO.	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease		14. INTERVAL BETWEEN ONSET AND DEATH 4200	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		15. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		16. ADDRESS Nelson Mays - Ash Grove - Mo.	
17a. ACCIDENT <input type="checkbox"/>	17b. SUICIDE <input type="checkbox"/>	17c. HOMICIDE <input type="checkbox"/>	
18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
19. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year			
20a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>	20b. NOT WHILE AT WORK <input type="checkbox"/>	20c. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. CITY, TOWN, OR LOCATION Springfield, Mo		21. COUNTY STATE	
22. I attended the deceased from Jan 28, 1957 to Sept 21, 57 and last saw ^{her} alive on Sept 20, '57 Death occurred at 4:28 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Don J. Silsby M.D.		22b. ADDRESS Springfield, Mo	
22c. DATE SIGNED 9-21-57		23. NAME OF CEMETERY OR CREMATORY Ash Grove Cemetery Ash Grove - Mo.	
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial		23b. DATE 9-23-57	
24. FUNERAL DIRECTOR Erwin - Daniel Ash Grove Mo		24. ADDRESS 9-24-57	
25. DATE RECD. BY LOCAL REG. 9-24-57		26. REGISTRAR'S SIGNATURE Edith Williamson	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases that are not listed must be clearly stated.

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 *Doyle L. Sauer*

Licensed Embalmer No. *4702*
P. O. Address. *Ashtabula*

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.