

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026677  
STATE FILE NUMBER

FILED JUL 23 1958 Registration District No. 316 Primary Registration District No. 3061 Registrar's No. 274

1. PLACE OF DEATH a. COUNTY <i>St. Francois</i>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Francois</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Flat River</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Flat River</i>		0 9 42 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>603 Taylor Ave. Flat River Mo.</i>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>603 Taylor Ave.</i>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Mr. Thomas Alfred Mayer</i>				First	Middle	Last	4. DATE OF DEATH Month Day Year <i>July 9 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 2-1870</i>		9. AGE (In years last birthday) <i>88 yrs 7 mos</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>St. Engineer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>St. Joseph Lead Co.</i>	11. BIRTHPLACE (City and state or country) <i>Bellemeir, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr. James Mayer</i>				14. MOTHER'S MAIDEN NAME <i>Sophie Cheston</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Carl Peterson - 603 Taylor Ave. Flat River, Mo.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)			DUE TO (c)			4200
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
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 <i>1957</i> to <i>July 8, 1958</i> and last saw <sup>her</sup> <sub>him</sub> alive on <i>July 8, 1958</i> Death occurred at <i>6:30 A. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>J. L. Foster M.D.</i>				22b. ADDRESS <i>De Sloger Mo</i>		22c. DATE SIGNED <i>7-14-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>July 12-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Francis Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>Bonnie Terre Route No. 1. Mo</i>			
24. FUNERAL DIRECTOR <i>Albert H. ... Flat River, Mo.</i>			ADDRESS	25. DATE RECD. BY LOCAL REG. <i>July 14, 1958</i>		26. REGISTRAR'S SIGNATURE <i>Esther Rudloff</i>	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service 742 300 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Alvin W. Hoal*.....

Licensed Embalmer No. *27*  
*303 Crane St.*  
P. O. Address *Flex. P. O.*

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.