

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016071

STATE FILE NUMBER

FILED MAY 15 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1161

300

1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside limits of TOWNSHIP only) OR TOWN St. Louis County,		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Co. Hospital		d. STREET ADDRESS (If outside, give location) 3209 Jasper Park	
3. NAME OF DECEASED (Type or print) First Carl Middle Last Mayer		4. DATE OF DEATH Month April Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3 WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-23-98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) Months Days Hours Min. 60
11. BIRTHPLACE (City and state or country) Louisiana		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Arthur Mayer		13b. MOTHER'S MAIDEN NAME Ida Bond	14. NAME OF HUSBAND OR WIFE rank
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. rank	17. INFORMANT Mrs. Frances Mikel Address 3209 Jasper Park
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary Artery Atherosclerosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Larynx - Resection 1952 & Active Pulmonary Tuberculosis.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 420.1H	
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 Death occurred at 4-16-59 to 4-27-59 and last saw him alive on 4-27-59 at 6:45 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. H. Garrison, Jr. M.A. (Degree or title)		22b. ADDRESS 601 S. Brentwood, Clayton, Mo.	22c. DATE SIGNED 4-27-59
23a. BURIAL CREMATION Removal	23b. DATE 4-29-59	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) (State) Jefferson Bks Mo.
24. FUNERAL DIRECTOR Edw. Fendler Mortuary 5611 So. Grand		25. DATE RECD. BY LOCAL REG. 4-28-59	26. REGISTRAR'S SIGNATURE John E. Murphy M.D.

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 *J. A. Kempney*

Licensed Embalmer No. *4772*

P. O. Address *Sullivan, Mo*

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.