

R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026938

FILED VS. JUL 24 1959

2 6639

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 50 yrs.	
c. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3960 Enright	
3. NAME OF DECEASED (Type or print) First George Middle Mayes Last Mayo		4. DATE OF DEATH Month 7 Day 13 Year 59	
5. SEX Male	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 4/18/1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY Self	9. AGE (last birthday) 78
11. BIRTHPLACE (City and state or country) Mayfield, Ky.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Sam Mayes		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Mattie		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. 492-16-3280		17. INFORMANT Mattie Mayes, 3960 Enright	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Benign Hypertrophy of the Prostate			6 mos
DUE TO (c) 610x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____		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 7-1-59 to 7-13-59 and last saw him alive on 7-13-59		Death occurred at 1:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Maude R. Keenford, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 7-14-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
23b. DATE 7/17/1959		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		24. FUNERAL DIRECTOR ADDRESS Chas. J. Gates 4107 Finney	
25. DATE RECD. BY LOCAL REG. JUL 15 '59		26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

BY AFFIDAVIT OF Funeral Director MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Av

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