

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 24 1960

2 2899 60-012947
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 21 yrs.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6128 Waterman		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 6128 Waterman
3. NAME OF DECEASED (Type or print) Carl Karl Mayer		4. DATE OF DEATH Month Mar. Day 11 Year 1960	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 5/18/90	9. AGE (last birthday) 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Textile Mill	11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Gustav Mayer	13b. MOTHER'S MAIDEN NAME Unk.
14. NAME OF HUSBAND OR WIFE Netta		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unk.
17. INFORMANT Address Netta Mayer 6128 Waterman		18. 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 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 420.0 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.	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 May 1956 to March 11, 1960 and last saw ^{her} him live on January 21, 1960 Death occurred at 12:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Gray H. Fainberg, M.D.	
22b. ADDRESS 216 So Kings Highway	22c. DATE SIGNED 3-11-60		23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.
23b. DATE 3/13/60	23c. NAME OF CEMETERY OR CREMATORY B'rith Sholom	23d. LOCATION (City, town, or county) University City, Mo.	(State)
24. FUNERAL DIRECTOR Berger Memorial 4715 Mc herson	25. DATE RECD. BY LOCAL REG. MAR 12 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.	

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

(H.T.)

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 *Lawrence J. DeWitt*

Licensed Embalmer No. 3988

P. O. Address _____

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.