

Dept. Health,
oc. & Welfare
J. S. Public
Health Service

V. S. 300
Rev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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FILED VS APR 26 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

=60-016186

STATE FILE NUMBER

Registration District No. 210 Primary Registration District No. _____ Registrar's No. 30

1. PLACE OF DEATH a. COUNTY Mercer			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Rock Island		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN North Marian Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Port Byron 81202		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR U.S. Highway # 65 INSTITUTION 1/2 mile So. Lincolville Ia.		Length of stay in lb 91	d. STREET ADDRESS (If outside, give location) 919 North River St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Leroy Maydon			4. DATE OF DEATH Month Day Year April 21, 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 June 17, 1892	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Rock Island R.R.	11. BIRTHPLACE (City and state or country) Iowa /		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Earl Grant Maydon		13b. MOTHER'S MAIDEN NAME Julia Jacobson		14. NAME OF HUSBAND OR WIFE Minnie Maydon	
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.	17. INFORMANT Minnie Maydon Address Port Byron, Ill.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH 3 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Coronary Heart Disease					yes.
DUE TO (c) Arteriosclerosis Chronic					yes.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201					18. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)		
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 _____, to _____ and last saw her/him alive on _____ Death occurred at 9:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Geo J Davison DO			22b. ADDRESS Box 98 Mena, Mo		22c. DATE SIGNED 4/21/60
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
BURIAL		4/23/60	Port Byron Cemetery		Port Byron, Illinois
24. FUNERAL DIRECTOR Ma Galloway, Lincolville, Ia		25. DATE RECD. BY LOCAL REG. 4-21-60	26. REGISTRAR'S SIGNATURE Neil Pratt		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

MAY 10 1930

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 *Paul J. Gravelle*

Licensed Embalmer No. *3967*

P. O. Address *Amerville, Va.*

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.