URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS MAY 3 1 1960

-60-018547

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. ____ Registrar's No. 292

ENDED

1. PLACE OF DEATH
a. COUNTY: Butler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Brosley — Length of stay in 1b: 34yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Butler
c. CITY OR TOWN: Brosley — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rt.One,Box II8 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Alge Middle: Silas Last: Mays

4. DATE OF DEATH: Month: May Day: 7 Year: 1960

5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9/I5/I897
9. AGE (last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): BeeBee, Ark.
12. CITIZEN OF WHAT COUNTRY: U.s.a.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Rosie Mays

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.: 7I9-I2-2779
17. INFORMANT — Address: Mrs. Rosie Mays,Brosley Mo.Rt.One.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 3/10/60
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Chronic Nephritis
DUE TO (c): Chronic Prostatitis

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 4-18-60 to 5-7-60 and last saw him alive on 4/18/60
Death occurred at 5:05 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J H Shelay MD
22b. ADDRESS: Poplar Bluff Mo
22c. DATE SIGNED: 5/13/60

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 5/II/1960
23c. NAME OF CEMETERY OR CREMATORY: Plesant Grove
23d. LOCATION (City, town, or county) (State): Harville,Mo.

24. FUNERAL DIRECTOR — ADDRESS: Peoples,Poplar Bluff,Mo.
25. DATE RECD. BY LOCAL REG.: 5/21/60
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF DOCUMENT

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 Fred J. Smith

Licensed Embalmer No. 4408

P. O. Address Siloston

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