

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021278

FILED VS MAY 25 1960

318

1003

5038

STATE FILE NUMBER

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

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 17yr 4mo 2dys		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 802 N. Jefferson			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Last Mays				4. DATE OF DEATH Month May Day 10 , Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/21/1900	9. AGE (last birthday) 53	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) UNKNOWN		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME William Mays Sr.			13b. MOTHER'S MAIDEN NAME Kate Black		14. NAME OF HUSBAND OR WIFE NONE		
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. NONE		17. INFORMANT Address Jarland Bright 4562 Ashland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Pulmonary Embolus						INTERVAL BETWEEN ONSET AND DEATH recent	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)						DUE TO (c) Left Femoral Vein Thrombosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 466X						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 checked="" type="checkbox"/> NO <input 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 Jan. 8, 1943 to May 10, 1960 and last saw her/him alive on May 10, 1960				Death occurred at 4:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.			22b. ADDRESS 5800 Arsenal			22c. DATE SIGNED 5/11/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-13-60	23c. NAME OF CEMETERY OR CREMATORY FATHER DICKSON Cem.		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, Mo.			
24. FUNERAL DIRECTOR McCLAIN			ADDRESS 2812 CASS	25. DATE RECD. BY LOCAL REG. MAY 13 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

22-12

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 Walter R. Williams

Licensed Embalmer No. 4926
5135 Lotus
P. O. Address _____

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.