

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025529

FILED VS. JUN 20 1960 347

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. *22*

1. PLACE OF DEATH a. COUNTY <b>STONE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Oklahoma</b> b. COUNTY <b>Payne</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Table Rock</b>		Length of stay in 1b <b>1 day</b>		c. CITY OR TOWN <b>Cushing</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bridgeview Resort</b>				d. STREET ADDRESS (If outside, give location) <b>Route # 2</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>B. HARRISON MAYS</b>			4. DATE OF DEATH Month Day Year <b>6-3-60</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-6-1909</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oil Production</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oil</b>		11. BIRTHPLACE (City and state or country) <b>Milan, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Ben Mays</b>			13b. MOTHER'S MAIDEN NAME <b>Ophelia Harrison</b>			14. NAME OF HUSBAND OR WIFE <b>Mrs Ouida Mays</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>443-03-7685</b>		17. INFORMANT Address <b>Msr B.H.Mays Cushing, Okla.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>B r a i n Concussion</b> DUE TO (b) <b>Plane crash</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) 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 checked="" 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.) <b>Plane crashed in making a landing.</b>			
20c. TIME OF INJURY Hour <b>7:10</b> p.m. Month, Day, Year <b>6-3-60</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>landing strip</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>Reeds Spring, Stone Missouri</b>	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>J. M. Walker Sheriff</b>				22b. ADDRESS <b>Mo. State acting corner</b>		22c. DATE SIGNED <b>6-11-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>6-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairlawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cushing, Okla</b>		
24. FUNERAL DIRECTOR ADDRESS <b>A. Leo Davis, Cushing, Okla</b>				25. DATE RECD. BY LOCAL REG. <b>6-17-60</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Elmer Brown</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS FEB 21 1967

JUN 21 1960

VS JUN 21 1960

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 Cobb*

Licensed Embalmer No. 4731

P. O. Address Branco

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.