

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 26 1960 318

1003

9972

-60-039993  
STATE FILE NUMBER

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

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis City.</u>		Length of stay in 1b <u>2 1/2 days</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cardinal Glennon Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2810 Madison St.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Bern Mathew</u>			First <u>John</u> Middle <u>KERRY</u> Last <u>Mayhorn</u>	4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-11-60</u>	9. AGE (at birth) If UNDER 1 YEAR: Months <u>2 1/2</u> Days <u>2 1/2</u> If UNDER 24 HR: Hours <u>2 1/2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME - <u>not known</u>		13b. MOTHER'S MAIDEN NAME <u>Deborah Mathew</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>John P. Mayhorn, MD - Cardinal Glennon</u> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Congestive heart disease</u>					
DUE TO (b) <u>Tricuspid atresia</u>					
DUE TO (c) <u>Ventricular septal defect</u>					<u>754-2</u>
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 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 ---Month, Day, Year a.m. : p.m. X- : :	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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>9 AM 10-13</u> <u>til 7 PM</u> to <u>10-13</u> and last saw her/him alive on <u>10-13</u> Death occurred at <u>up town 6:40 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John P. Mayhorn, MD</u>			22b. ADDRESS <u>40 Cardinal Glennon</u>		22c. DATE SIGNED <u>10-13</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	(State)
<u>removal 10/4/60</u>	<u>10/4/60</u>	<u>Deerwood</u>		<u>St. Louis, Mo.</u>	<u>Mo.</u>
24. FUNERAL DIRECTOR <u>Dates Funeral Home</u>		ADDRESS <u>40 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 14 1960</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

**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 Not embalmed Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Rayton  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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

10-17-01