

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041042

FILED VS NOV 28 1960

38

Registration District No. 38 Primary Registration District No. 3096

Registrar's No. 649

STATE FILE NUMBER

VD

DOCUMENT

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY CANAWAY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Length of stay in lb 8 days	c. CITY OR TOWN Cedar City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION (if NOT in hospital, give location) UNIVERSITY OF MO. Medical Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Box 15 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Jessie RAYMOND MAYES			4. DATE OF DEATH Month Day Year 11-23-60			
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 5-20-13	9. AGE (last birthday) 47	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GRACERMAN		10b. KIND OF BUSINESS OR INDUSTRY GRACERMAN		11. BIRTHPLACE (City and state or country) Boone County Mo. U.S.		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME David MAYES		13b. MOTHER'S MAIDEN NAME Callie Stone		14. NAME OF HUSBAND OR WIFE Dorothy MAYES		
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. 499-05-8455		17. INFORMANT University of Mo. Medical Center Address Always		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNDIFFERENTIATED CARCINOMA PROBABLY FROM THYROID		INTERVAL BETWEEN ONSET AND DEATH 9 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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"/> N. <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 **11-15-60** to **11-23-60** and last saw her alive on **11-23-60**
 Death occurred at **2:25 AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Declarer or title) Erna Richard Smith, M.D.		22b. ADDRESS Univ. Med Center		22c. DATE SIGNED 11/23/60
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Nov 23-60	23c. NAME OF CEMETERY OR CREMATORY Gullerson City		23d. LOCATION (City, town, or county) (State) Mo.
24. FUNERAL DIRECTOR Sylvester Dulle of C Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. Nov 23 1960	REGISTRAR'S SIGNATURE Mrs. R. E. Palmer	

BY AFFIDAVIT OF

VS DEC 8 1966

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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 _____

Sylvester Dulle

Licensed Embalmer No. 452

P. O. Address Jefferson City

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.