

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000262

FILED VS JAN 24 1961

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 4

STATE FILE NUMBER

AMENDED

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Boone</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Length of stay in 1b <u>5 months</u>		c. CITY OR TOWN <u>Centralia</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>Way Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>329 S. Allen</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Lee</u> Last <u>Mayer</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/27/1876</u>		9. AGE (last birthday) <u>84</u> IF UNDER 1 YEAR IF UNDER 24 HR Months <u>10</u> Days <u>17</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Audrain County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Drury Mayer</u>			13b. MOTHER'S MAIDEN NAME <u>Mary James</u>			14. NAME OF HUSBAND OR WIFE <u>Julia Mayer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Jack McDaniel, K.C. Kansas</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Recurrent Cerebral Hemorrhages</u> DUE TO (c) <u>Arteriosclerosis of Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardio Renal Syndrome</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								INTERVAL BETWEEN ONSET AND DEATH <u>42 hr</u> <u>5 mo.</u> <u>year</u>	
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.) <u></u>					
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> p.m. <u></u>		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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>2-20-46</u> to <u>1-14-61</u> and last saw him alive on <u>1-14-61</u> Death occurred at <u>2:58 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Drury Mayer DO</u>				22b. ADDRESS <u>Centralia Mo</u>		22c. DATE SIGNED <u>1-16-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 16, '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>		23d. LOCATION (City, town, or county) <u>Centralia, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>One E. Meador Centralia, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>Jan. 17-1961</u>		26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>			

JAN 25 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Billy J. Meadows

Licensed Embalmer No. 4876

P. O. Address Centralia, Mass

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.