

318

1003

6010

STATE FILE NUMBER

AMENDED

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

FILED JUL 7 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM 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 Missouri. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 2 yrs 3 mo. 14 days	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3851 Dunnica		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha A. Mayford			4. DATE OF DEATH Month Day Year 6 26 61			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1884	9. AGE (last birthday) 76 yrs.	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) Domestic work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Alton, Illinois.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Henry Mayford		13b. MOTHER'S MAIDEN NAME Elizabeth Heathering		14. NAME OF HUSBAND OR WIFE Nil.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Chris Mayford, Woodriver, Illinois.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> No <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 <u>3-11-59</u> to <u>6-26-61</u> and last saw her/him alive on <u>6-26-61</u> Death occurred at <u>3:40 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>John Smith</i> (Degree or title) <i>MD</i>			22b. ADDRESS <i>5600 Arsenal St.</i>		22c. DATE SIGNED <i>6/27/61</i>	
23a. BURIAL CREATION, REMOVAL (Specify) Removal	23b. DATE 6-28-61	23c. NAME OF CEMETERY OR CREMATORY Upper Alton Cemetery		23d. LOCATION (City, town, or county) (State) Alton, Illinois.		
24. FUNERAL DIRECTOR Marks Funeral Home, Woodriver, Ill.		25. DATE RECD. BY LOCAL REG. JUN 28 1961	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.