SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10355 STATE FILE NUMBER 38951

FILED NOV 10 1961

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | Length of stay in 1b

c. CITY OR TOWN St. Louis | Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips | Inside Limits Yes ☑ No ☐

d. STREET ADDRESS (If outside, give location) 4438 Enright | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Albert Middle: Last: Mays

4. DATE OF DEATH Month: 11 Day: 4 Year: 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Aug 10, 1893

9. AGE (last birthday): 68

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HR: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Century Electric

11. BIRTHPLACE (City and state or country): Ark.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Calvin Mays

13b. MOTHER'S MAIDEN NAME: Sallie Unknown

14. NAME OF HUSBAND OR WIFE: Sophronie Mays

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

17. INFORMANT: Sophronia Mays Address: 4438 Enright

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: Undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Bladder Neck Obstruction — Undet.

DUE TO (c) Benign Prostate Hyperplasia — Undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 610 X

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 10-20-61, to 11-4-61 and last saw ~~him~~ alive on 11-4-61

Death occurred at 8:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: N. Prophete (Degree or title) MD

22b. ADDRESS: 2601 N. Whittier Street

22c. DATE SIGNED: 11-6-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11-8-61

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

23d. LOCATION (City, town, or county): St. Louis Co. (State): Mo.

24. FUNERAL DIRECTOR: Dunn Funeral Home ADDRESS: 3847 Page

25. DATE RECD. BY LOCAL REG.: NOV 7 1961

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

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