

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 0001251 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 6 1964

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		c. CITY OR TOWN <u>Montrose</u>	
Length of stay in 1b <u>12 days</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>Clinton General Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>RFD. # 1,</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>-</u> Last <u>Mayes</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>1,</u> Year <u>1964</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>8/30/1877</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Henry Co., Mo.</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Isaac Elledge</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Bryan</u>		14. NAME OF HUSBAND OR WIFE <u>John H. Mayes</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>486 24 1396</u>	17. INFORMANT <u>RFD. #1, Dorothy L. Mayes, Montrose, Mo.</u>		

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>Hypostatic Pneumonia</u>		<u>2 1/2 days</u>
DUE TO (b) <u>Coronary Occlusion</u>		<u>12 days</u>
DUE TO (c) <u>Atherosclerotic Heart disease</u>		<u>2 years.</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 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 <u>6:50</u> a.m. p.m. Month, Day, Year <u>12/20/63</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.)		20f. CITY, TOWN, OR LOCATION <u>Clinton Missouri</u>	
20g. COUNTY <u>Henry</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>12/20/63</u> to <u>1/1/64</u> and last saw her <u>live</u> on <u>1/1/64</u> Death occurred at <u>6:50 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. R.S. Hallingworth M.D.</u>		22b. ADDRESS <u>Clinton Missouri</u>	22c. DATE SIGNED <u>1/2/64</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 3, 1964</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LaDue Cemetery</u>	23d. LOCATION (City, town, or county) <u>LaDue, Missouri</u>
24. FUNERAL DIRECTOR <u>Vansant Funeral Home, Clinton, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN. 2, 1964</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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9	<u>4/201</u>
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13	<u>1-0</u>

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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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. J. Vansant

Licensed Embalmer No. 3779

P. O. Address Clinton, Mo.

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.