

FILED JUL 6 1947 91

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Clyde Claude Mayberry

3. (b) If veteran, name war no 3. (c) Social Security No. 496-18-6920

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May 10 1921
(Month) (Day) (Year)

8. AGE: Years 21 Months 1 Days 11 If less than one day hr. min.

9. Birthplace Winona Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Ben Mayberry
13. Birthplace Winona Mo
(City, town, or county) (State or foreign country)
14. Maiden name Hattie Barbs
15. Birthplace Winona Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Hattie Mayberry
(b) Address Winona Mo

17. (a) (b) Date thereof 6-23-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winona Mo

18. (a) Signature of funeral director Seichel J.H.

(b) Address Wagon Bureau, Mo.

19. (a) JUN 8 1947 (b) J. F. Bodeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0
(c) City or town Winona (If outside city or town limits, write "RURAL") NR
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21 year 1942 hour 12 minute 17 P.M.

21. I hereby certify that I attended the deceased from May 7, 1942, to June 21, 1942 that I last saw him alive on June 21, 1942 and that death occurred on the date and hour stated above.
Immediate cause of death Actinomycosis

Due to.....
Due to.....
Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations.....
Of autopsy None obtained

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury 0
23. Signature F.R. Bradley (M. D. or D.V.M.)
Address BARNES HOSPITAL Date signed 6-21-42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Heward M. Rowland

Licensed Embalmer No. *3114*

P. O. Address *Thomas 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 this body is not embalmed, fact should be so stated above.