

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-041795**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10001

**FILED OCT 17 1963**

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

GATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |                  |   |  |  |   |  |                             |                             |  |   |      |
|---|------------------|---|--|--|---|--|-----------------------------|-----------------------------|--|---|------|
| 1. PLACE OF DEATH<br>a. COUNTY  |                  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN  |  | Length of stay in 1b   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  | b. COUNTY                   | c. CITY OR TOWN             |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |                  | 3338 Wisconsin Ave  |  | Yes <input type="checkbox"/> No <input type="checkbox"/>                                     | d. STREET ADDRESS<br>3338 Wisconsin Ave   |  | (If outside, give location) |                             | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |      |
| 3. NAME OF DECEASED<br>(Type or print)  |                  |   | First  | Middle   | Last  | 4. DATE OF DEATH<br>Month                  |                             | Day                         | Year   |   |      |
| Frank   |                  |   |  |  | Mayer   | Oct.                                       |                             | 6                           | 1963   |   |      |
| 5. SEX  | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH   |  | 9. AGE (last birthday)  | IF UNDER 1 YEAR<br>Months                  |                             | Days                        | IF UNDER 24 HR<br>Hours  |   | Min. |
| Male  | White            |   | 10/14/1889   |  | 73  |  |                             |                             |  |   |      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country) |                             | 12. CITIZEN OF WHAT COUNTRY |  |   |      |
| Retired Ice Puller  |                  |   |  |  |   | Missouri                                   |                             | U S A                       |  |   |      |
| 13a. FATHER'S NAME  |                  |   |  | 13b. MOTHER'S MAIDEN NAME  |   | 14. NAME OF HUSBAND OR WIFE                |                             |                             |  |   |      |
| James Mayer   |                  |   |  | Elizabeth Liggett  |   | Esther Mayer                               |                             |                             |  |   |      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)   |                  |   |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br>Address                   |                             |                             |  |   |      |
| No  |                  |   |  |  |   | Esther Mayer 3338 Wisconsin                |                             |                             |  |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u><br>DUE TO (b) <u>Generalized Arterio Sclerosis</u><br>DUE TO (c) <u>420.0</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                  |   |  |  |   |  |                             |                             |  |   |      |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour<br>a.m.<br>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 _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.  |                  |   |  |  |   |  |                             |                             |  |   |      |
| 22a. SIGNATURE<br><i>Robert J. Smith</i> (Degree, Title)  |                  |   |  | 22b. ADDRESS<br>1300 Clair   |   |  |                             | 22c. DATE SIGNED<br>10-8-63 |  |   |      |
| 23a. BURIAL, REMOTION, REMOVAL (Specify)  |                  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town, or county)      |                             | 23e. STATE                  |  |   |      |
| Removal   |                  | Oct. 10, 1963   |  | St. Trinity Lutheran   |   | St. Louis Co.                              |                             | Mo                          |  |   |      |
| 24. FUNERAL DIRECTOR<br>ADDRESS   |                  |   |  | 25. DATE RECD. BY LOCAL REG.   |   | 26. REGISTRAR'S SIGNATURE                  |                             |                             |  |   |      |
| Thomas Kutis 2906 Gravois   |                  |   |  | OCT 8 1963   |   | Robert Smith, M.D.                         |                             |                             |  |   |      |

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 groves

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.

*Province*

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