

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041796

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10965 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS 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 <u>mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>6 year</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>Missouri Pacific Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>3136^A Brantner</u>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Andrew</u> Last <u>Mayo</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>4</u> - Year <u>63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</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>1-13-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rail Road worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Louisiana</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
13a. FATHER'S NAME <u>Peter Mayo</u>		13b. MOTHER'S MAIDEN NAME <u>Lelia Mayo</u>	
14. NAME OF HUSBAND OR WIFE <u>Lelia Mayo</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Lelia Mayo 3136^A Brantner</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease 2 years</u> DUE TO (c) <u>4200</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 _____ 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>1960</u> to <u>Oct. 31, 63</u> and last saw him alive on <u>Oct. 31</u> Death occurred at <u>6:00 clock</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John McFarato M.D.</u>		22b. ADDRESS <u>Mo. Pac. R.R. Hospital</u>	
22c. DATE SIGNED <u>11-5-63</u>		22d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>	23b. DATE <u>11, 4, 63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Watson</u>	
24. FUNERAL DIRECTOR <u>A H Burks 3901 Ashland</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 5 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Road Smith, M.D.</u>			

NOT FOR SALE

STATE

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STATEMENT BY LICENSED EMBALMER

6-98

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 No Embalming
C. H. Bush
Licensed Embalmer No. _____
P. O. Address Undertaker

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.