WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Scott

Township Richland or Village ____ or City ____ (NO. ____ St.; ____ Ward)

Registration District No. 8 21 File No. 21954

Primary Registration District No. 6070 Registered No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Goldie Mary Mayfield

2-1

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Infant

DATE OF BIRTH: May (Month) 29 (Day), 1912 (Year)

AGE: ____ yrs. ____ mos. 6 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE (City or town, State or foreign country) Sikeston Mo.

PARENTS
NAME OF FATHER: Jeff. J. Mayfield
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill.
MAIDEN NAME OF MOTHER: Stella H. Winters.
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Oscala Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Mayfield
(ADDRESS) Sikeston Mo.

Filed June 8, 1912 J. A. Milam REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 3 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Died without medical, 191__, to attention, 191__, that I last saw h__ alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Convulsions supposed to be due to indigestion
118C
86 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) Indigestion (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. J. Mayfield Chauncey Dwyer M.D.
June 8 1912 (Address) Sikeston Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Minerdsich
DATE OF BURIAL: June 4 1912
UNDERTAKER: Hodnone
ADDRESS: ____

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS