APR 23 1926
140

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

8711

1. PLACE OF DEATH
County Jasper — Registration District No. 407 — File No.
Township — Primary Registration District No. H241 — Registered No. 7
City Carterville (No. ..... St. ..... Ward)

2. FULL NAME Audine Mayfield
(a) Residence. No. 134 E. Wilson St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 1907
7. AGE Years 18 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) Carterville
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Chas. Mayfield
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Tracy Walker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Mrs. Tracey Mayfield
(Address) Carterville Mo.
15. FILED 3-10 1926 C L Gray REGISTRAR

2 **MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-9-1926
17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1926 to March 9, 1926 that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 3.30 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
11A
107A
100 a
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Flu
(duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
0 DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & X Ray
(Signed) B A Dumbaulet, M.D
3/10, 1926 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Carterville Cem — DATE OF BURIAL 3/10 1926
20. UNDERTAKER Webb City Wood Co. — ADDRESS Webb City

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....,.....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to .....; 19.....
that I last saw h..... alive on.....,19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....,M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.

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