

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

Do not use this space.

21633

2713

**1. PLACE OF DEATH**

County Jackson  
Township W. 1st  
City K.C. Mo. (No. 810 Indiana

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 810 Indiana St. 9 Ward.

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX \_\_\_\_\_ 4. COLOR OR RACE In White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July - 17 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
67 10 9

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. at home  
(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) Leah, Mo.

10. NAME OF FATHER L. N. Graham

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

12. MAIDEN NAME OF MOTHER Elij.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no Record

14. INFORMANT W. B. Mayfield (Address) 810 Indiana Ave

15. FILED 7/24/29 1929 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 21 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1 1929 to June 21 1929 that I last saw him alive on June 21 1929, and that death occurred, on the date stated above, at 6:35 P.M. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pneumonia pneumonia  
92A  
71A

CONTRIBUTORY (SECONDARY) Myocard Regurg (duration) 3 yrs. mos. ds.  
2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
(Signed) P. L. St. Clay M. D.  
June 21, 1929 (Address) 5242 St. Julian

\*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Memorial Park DATE OF BURIAL June 27 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

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.

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