

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

Do not use this space.

Roseberry
15859

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.
 Township Springfield Primary Registration District No. 2001 Registered No. 381
 City Springfield (No. Baptist Hospital) St. Ward)

2. FULL NAME Irvin W. Mayfield

(a) Residence. No. Lebanon 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 <u>M</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
5A. MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah A. Mayfield</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 4 1861</u>		
7. AGE	YEARS <u>69</u>	MONTHS <u>4</u>
	DAY <u>12</u>	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Leclade Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm R. Mayfield

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

12. MAIDEN NAME OF MOTHER Ann Adams

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

14. INFORMANT Irvin Mayfield
 (Address) Lebanon Mo.

15. FILED 5/17/30 Gos Sharp REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/16/30

17. I HEREBY CERTIFY, That I attended deceased from 4/11/30 to 5/16/30
 and that I last saw him alive on 5/16/30 and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Collapse following typhoid & smallpox operation
1218 (duration) yrs. mos. ds.
1274 222
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? Lebanon Mo
 IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4/18-30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

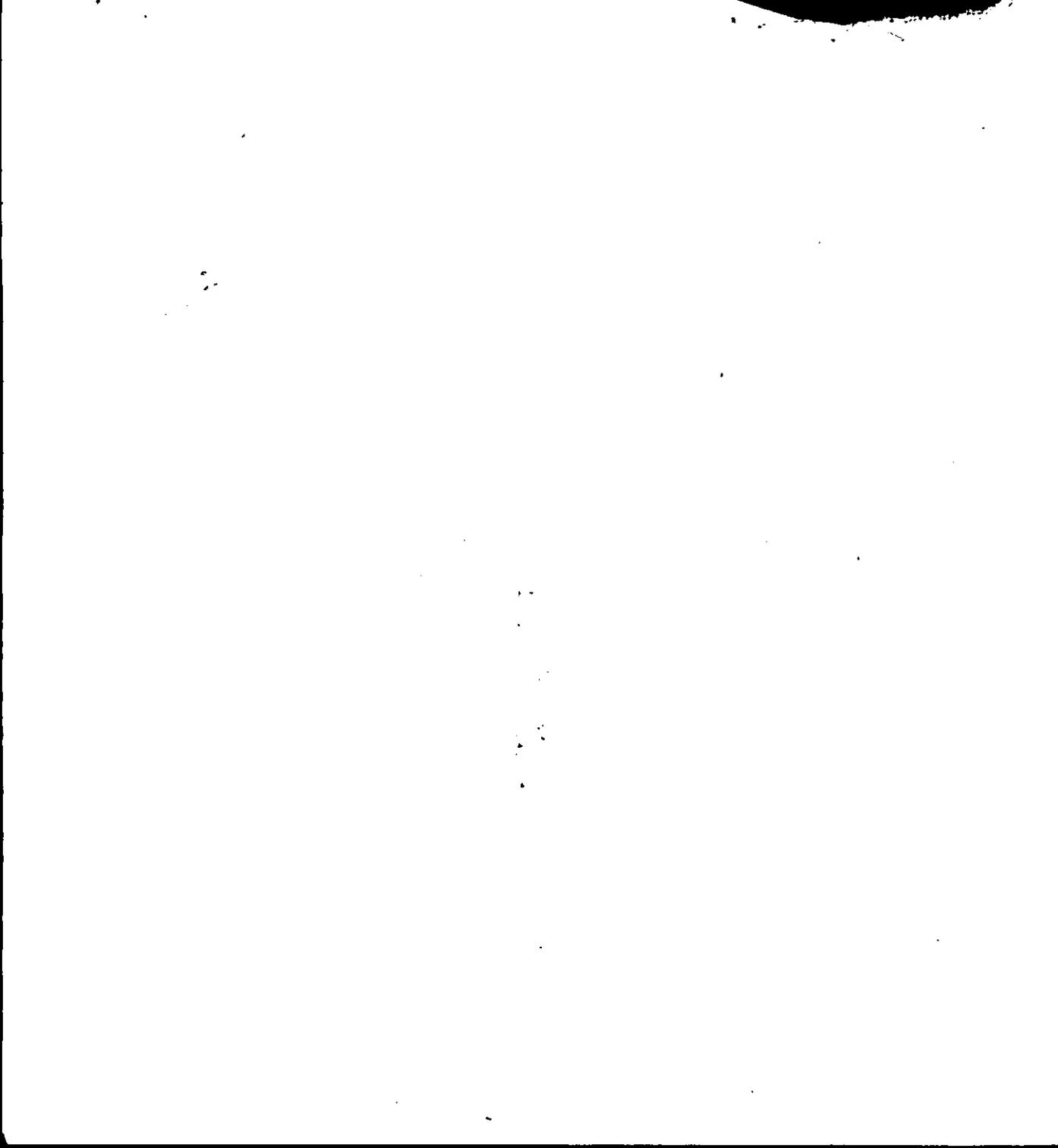
(Signed) E. L. Roseberry, M. D.
 (Address) Springfield Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lebanon Mo. **DATE OF BURIAL** 5-17-30

20. UNDERTAKER Alma Schreyer **ADDRESS** 534 1/2 St. Main

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE Exact statement of OCCUPATION is very important.



cated by check marks, lacking from the death certificate:

381

Name: Irvin W. Mansfield

Who died at: Springfield Mo. on May 16, 1930

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single; married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Circulatory Collapse

following Appendix and Gall

Bladder Operation

no other cause given

Where was disease contracted? _____

Did operation precede death? yes Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: _____

8.—Every item of information...

S-15859