

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

Do not use this space.

39070

**1. PLACE OF DEATH**

County Greene

Registration District No. 317

Township

Primary Registration District No. 4192

City

Republic

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward) \_\_\_\_\_

**INFANT OF J.A. MAYFIELD**

**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**

FEMALE

**4. COLOR OR RACE**

WHITE

**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) DEC. 23 1930**

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, 18 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)

MISSOURI

**10. NAME OF FATHER**

JAMES MAYFIELD

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

MISSOURI

**12. MAIDEN NAME OF MOTHER**

Mrs. A. Young

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

MISSOURI

**14. INFORMANT**

(Address)

James A. Mayfield  
Republic Mo.

**15. FILED**

12/26 1930

v. w. shover  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Dec. 26 1930

**17.**

I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to Dec 26, 1930 that I last saw him alive on Dec 26, 1930 and that death occurred, on the date stated above, at 4 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

159 Inaction  
158  
(duration) yrs. 18 mos.

**CONTRIBUTORY (SECONDARY)**

Inefficient Lung development  
(duration) yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

at her Home

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

Physical Signs

(Signed)

E. R. Beal

M. D.

, 19 \_\_\_\_\_ (Address)

Republic 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**

**DATE OF BURIAL**

Trail Cemetery

12/27 1930

**20. UNDERTAKER**

**ADDRESS**

R. H. ...  
Republic 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.

44419 1930

