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

Do not use this space.

26239

1. PLACE OF DEATH
County Jackson — Registration District No. — File No. 3147
Township Blue Kaw — Primary Registration District No. — Registered No.
City Kansas City Mo (No. Reeds Hospital St. Ward)

2. FULL NAME Wm Mayfield
(a) Residence, No. 426 Bales St., 9 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: Male
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: —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 10-15-13
7. AGE: YEARS 18 MONTHS 9 DAYS 29 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 237
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

FATHER
13. NAME: Mayfield Wm H.
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER
15. MAIDEN NAME: Kayton Josie
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): R. C. Tuberculosis Hosp
18. BURIAL, CREMATION, OR REMOVAL
PLACE Slater, Mo DATE 8-16-32
19. UNDERTAKER (ADDRESS): Mrs. C. L. Forstus
20. FILED Aug 15, 1932 M. M. Crowe Asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug-14-1932

22. I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1931, to Aug. 14, 1932
I last saw him alive on Aug 14, 1932 Death is said to have occurred on the date stated above, at 11:40 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of Onset
Pulmonary Tuberculosis	Apr
23A	
23	
Other contributory causes of importance: None	
None	

Name of operation: None Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury None
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [illegible] D.
(Address) Kansas City Mo

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.

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

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