

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Wheat  
City Kansas City (No. 1007)

Registration District No. 389  
Primary Registration District No. 1007

File No. 29360  
Registered No. 3534 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 3218 Nicholas St. Ward 9

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 37 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 21 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
58 9 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Night watchman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 187 1

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) Nebr. 2

13. NAME James Mayfield

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

15. MAIDEN NAME Sarah Coffee

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

17. INFORMANT (ADDRESS) The Caretaker  
W.C. Gen. Hosp. K.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE 9-19-32 19.

19. UNDERTAKER (ADDRESS) Frank Robbin  
Woodward

20. FILED 9/18 1932 M. M. Crowe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-16 1932

22. I HEREBY CERTIFY, That I attended deceased from 8-11 1932 to 9-16 1932

I last saw him alive on 9-16 1932 Death is said to have occurred on the date stated above, at 5:15 P. m.

The principal cause of death and related causes of importance were as follows:

Cardiac Decomposition  
with chronic nephritis

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1932

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 \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) P. E. Williams M. D.

9-19-32 (Address) Sup. K. Gen. Hosp. K. 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.

