

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

Do not use this space.

SEP 20 1935

26150

1. PLACE OF DEATH

County Green Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 209 Registered No. 335
City Springfield (No. Baptist Hospital) Ward _____

2. FULL NAME

James Henry Mayfield
(a) Residence, No. Seymour, Mo. Ward _____ (If nonresident, give city or town and State)
(Usual place of abode)

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 m 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 Jane Mayfield

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2 of Feb 1836

7. AGE YEARS 68 MONTHS 7 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.

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

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

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) Illinois

13. NAME James Mayfield

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

15. MAIDEN NAME Emma Walker

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

17. INFORMANT Mr. W. R. Jones (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Seymour DATE Aug 3 1935

19. UNDERTAKER Kelley - Starr (ADDRESS) Seymour, Mo.

20. FILED 8-1 1935 R. W. Anderson Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1st 1935

22. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1935, to Aug 1st 1935

I last saw him alive on Aug 1st 1935 Death is said to have occurred on the date stated above, at 5 m.

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

Cerebral Hemorrhage July 31.
186 112

Other contributory causes of importance: _____

Name of operation None Date of _____

What test confirmed diagnosis? ✓ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide _____ Date of injury 8/1 1935

Where did injury occur? Home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fell into ditch
Nature of injury Green, scalp, probable ruptured cerebral artery

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) T. H. Johnson M. D.

(Address) Springfield 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.

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no. of 2

