

REC'D JUN 8 1939

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

18624

Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 318
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 395
(c) City SPRINGFIELD (d) Street No. 223 W. NICHOLS St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

ELLI S. W. MAYFIELD
(a) Residence, No. 223 W. NICHOLS St. (If nonresident, give city or town and State)

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 Lillian B. Mayfield

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
60 8 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Flagman
9. Industry or business in which work was done, as saw mill, bank, etc. Frisco R.R. Co.
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) Mo.

FATHER 13. NAME Elisha Mayfield

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

MOTHER 15. MAIDEN NAME Nancy Crawford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Carolina

17. INFORMANT (ADDRESS) Lillian B. Mayfield
Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Lawn DATE May 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. M. Hughes
Springfield, Mo.

20. FILED 5-17-1939 Chas. A. George M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 10 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw him alive on 5-10 1939. Death is said to have occurred on the date stated above, at 12:10 P.M.

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

Congestive heart failure.

Marked pulmonary emphysema and chronic pulmonary fibrosis (bronchiectatic).

Arteriosclerosis of pulmonary vessels.

Other contributory causes of importance: Chronic myocardial disease

Name of operation Autopsy Date of 9-3-39

What test confirmed diagnosis? Autopsy 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 -, 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 -

Nature of injury -

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify -

(Signed) Sheffner M. D.

(Address) Springfield, Mo.

JAN 4 1914

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Ray A. Baum

Licensed Embalmer No. *1763*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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