

No. 2  
11-10-39  
17-39  
7 MAR 1942

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11375

Registration District No. 411 Primary Registration District No. 5569 Registrar's No.

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Jasper  
(c) Name of hospital or institution R.I. - Joplin  
(d) Length of stay: In hospital or institution 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Joplin  
(d) Street No. R#11  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Pansy Loretta Mayfield

3. (b) If veteran, name war 1. 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edward Mayfield 6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased (Month) Feb (Day) 9 (Year) 1923

8. AGE: Years 17 Months 1 Days 19 hr. min.

9. Birthplace Oak Junction, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

12. Name Frank B. Bryant

13. Birthplace Jasper, Missouri (City, town, or county) (State or foreign country)

14. Maiden name Emma May Turner

15. Birthplace Joplin, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Edward C. Mayfield

(b) Address R#1 Joplin

17. (a) Burial (b) Date thereof Mar 30, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Peace Cemetery

18. (a) Signature of funeral director M. L. ...

(b) Address ...

19. (a) 3-29-40 (b) Ed D. Jarney (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28 year 1940 hour 5 minute 50 P. M.

21. I hereby certify that I attended the deceased from Dec 2-1939 to March 29 1940

that I last saw him alive on March 27 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer - (Metastatic)

Due to Pulmonary Abscess

Due to Acetates

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations x Ray findings Of autopsy Autopsy by ...

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work 3:10 (Specify type of place) (e) Means of injury

23. Signature A. H. ... (or other) Address 2114 Joplin Date signed 3/29/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 440-1055

Date Filed APR 1 0 1940

92 W

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11375-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 411

Primary Registration District No. 5369

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Balton, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Pansy Loretta Mayfield

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 1 19 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure  
Medical Insufficiency

Due to Pulmonary abscess  
None Inter-ventricular  
Due to aortic

Other conditions 9 2 6  
(Include pregnancy within 3 months of death)

Major findings: Ray Frisling  
Pulmonary abscess  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. W. Deffelt (M.D. or other) \_\_\_\_\_

Address Jefferson Date signed \_\_\_\_\_

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

11375 (1940)