

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37889**
4487

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Conley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 months**
(Specify whether years, months or days)
In this community **5 years**

3. (a) PRINT FULL NAME **George Calvin Mayfield**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Myrtle Mayfield** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **Jan. 19, 1886**
(Month) (Day) (Year)

8. AGE: Years **54** Months **10** Days **3** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Riley Mayfield** 9

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

14. Maiden name **Sophrona Landreth**

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

16. (a) Informant **Mrs. Myrtle Mayfield**

(b) Address **2017 Poplar, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 25-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Floral Hills**

18. (a) Signature of funeral director **C.H. Blackman & Son, Inc.**

(b) Address **K.C. Mo.**

19. (a) **11-25-40** (b) **M. M. Crome**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **2017 Poplar**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **22**
year **1940** hour **1:54 pm** minute _____ M.

21. I hereby certify that I attended the deceased from **Sept 29th** 1940 to **Nov 22nd** 1940
that I last saw him alive on **Nov 22nd** 1940
and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis & surgical shock** Duration _____

Due to **Sepsis, Osteomyelitis & deep lacerations**

Due to **Fracture of tibia & fibula** 1885

Other conditions (Include pregnancy within 3 months of death) **1885**

Major findings: **Amputation above right knee because of cellulitis & osteomyelitis**
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) **Acc**

(b) Date of occurrence **9-3-1940**

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

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

While at work? **Yes** (Specify type of place) **Kicked by Colt**
(e) Means of injury **Colt**

23. Signature **J. M. Williams** (M. D. or other) **MD.**

Address **2165 Independence** Date signed **Nov 3/40**

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

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 B. H. Blackman
Licensed Embalmer No. 2244

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.