. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Permit no. 103 April 6 - 1945 18449
State File No.

FILED MAY 17 1945

Registration District No. 35

Primary Registration District No. 6220

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Rural Harison Lin 0
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5 mi. East of Garland Ks.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether
In this community 2 mo. 10 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Vernon 108

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 5mi. East of Garland Ks.
(If rural, give location)

(e) Citizen of foreign country? -Yes- NO 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Larry Dean Mayfield

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Simgle

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan. (Month) 25 (Day) 1945 (Year)

8. AGE: Years | Months 2 | Days 10 | If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Everett L. Mayfield Jr.
13. Birthplace Bronaugh (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Ida Kathleen Griffeth
15. Birthplace Bronaugh (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Ida Kathleen Griffeth
(b) Address Bronaugh Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/45 (Month) (Day) (Year)
(c) Place: burial or cremation Clarksburg

18. (a) Signature of funeral director [signature]
(b) Address Garland Kans.

19. (a) April-20-1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4
year 1945 hour 1 minute 20 PM

21. I hereby certify that I attended the deceased from Jan 25, 1945 to Apr 4th, 1945
that I last saw him alive on March 28, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital heart disease failure of closure foramen ovale

Due to "Blue Baby"

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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

23. Signature F. Young (M. D. or other)
Address Fort Scott Kans Date signed 4/9/45

1317

(Licensed Embalmer's Statement on Reverse Side)

REDEEMED
District Health Officer No. 7
District File Number 4-45-491
Date Filed 5-13-45

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. E. Huffines

Licensed Embalmer No. 2530

P. O. Address Garland Kans

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, fact should be so stated above.