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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9911

State File No. _____

FILED MAR 21 1947

Registration District No. 192

Primary Registration District No. 5706

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County McDonald

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

(c) Name of hospital or institution:
Two miles northwest Anderson Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community 55 years
years, months or days

3. (a) PRINT FULL NAME JOHN CARR MAYFIELD

3. (b) If veteran, name war World War 1

3. (c) Social Security No. NONE

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Vesta Mayfield

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased July 7 1891
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

55	8	5	hr. min.
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9. Birthplace McDonald County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name W. A. Mayfield

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

14. Maiden name Georgia McNatt

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

16. (a) Informant Vesta Mayfield

(b) Address Anderson, Missouri

17. (a) Burial (b) Date thereof 3-14-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson Cemetary

18. (a) Signature of funeral director Chas. W. Williams

(b) Address Goodman, Missouri

19. (a) 4-1-47 (b) Virginia Buck
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald

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

(d) Street No. Two Miles Northwest Anderson, Mo.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12
-- year 1947 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from Mar 11-47
to Mar 12 1947

that I last saw him alive on Mar 11 - 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure
Chronic Myocarditis
Influenza

Due to _____

Duration 2 days

Due to _____

Other conditions Urthral structure poor
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 93D

Underline the cause to which death should be charged statistically.

22. If death was due to external cause, 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 (c) Means of injury _____

23. Signature H. V. Blankenship (M. D. or other) M.D.
Address Anderson Date signed 3-14-47

(Licensed Embalmer's Statement on Reverse Side)

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APR 4 19

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 *John B. Papinesu*
Licensed Embalmer No. 4446
P.O. Address Goodman, Missouri

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 192

Primary Registration District No. 5706

Registrar's No. 5

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Rural
(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 years, months or days)

3. (a) PRINT FULL NAME John C. Mayfield
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 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

7. Birth date of deceased (Month) (Day) (Year) July 7

8. AGE: Years 55 Months Days If less than one day min. hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-10-47 (b) Virginia Buck
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1947 hour 2 minute 2 M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-9911