No. 300
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 6753 2315

FILED MAR 15 1948

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

**1. PLACE OF DEATH:**

(a) County

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

(c) Name of hospital or institution: Homer G Phillips Hospital 0
(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)

**2. USUAL RESIDENCE OF DECEASED:** 040

(a) State Missouri (b) County

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3337 Laclede 9
(If rural, give location) 0

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

3. (a) PRINT FULL NAME Mary Mayfield

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female 2

5. Color or race Negro

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

6. (b) Name of husband or wife Oscar H. Mayfield

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December (Month) 25 (Day) 1907 (Year)

8. AGE: Years 40 Months 2 Days 10 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER

12. Name Charles Isaiah Ashford

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

14. Maiden name Lillie Knox

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

16. (a) Informant Oscar H. Mayfield

(b) Address 3337 Laclede

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-7-48 (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director

(b) Address 1721

19. (a) MAR 9 1948 (Date received local registrar) (b) J.T. Bruedeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar. day 5 year 1948 hour 7 minute 35 P.M.

21. I hereby certify that I attended the deceased from 2-26, 1948, to 3-5, 1948, that I last saw her alive on Mar. 5, 1948, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Subarachnoid Hemorrhage | Undet. |
| Due to | |
| Due to | |
| Other conditions Uremia (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy None

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 0

23. Signature Oscar L Daniels (M. D. or other)

Address 2601 N Whittier Date signed 3/6/48

(Licensed Embalmer's Statement on Reverse Side)

2315

## 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 Wm Smith

Licensed Embalmer No. 4371

P. O. Address St Louis Mo

**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.**

o. 2B
5-43
X36930

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

State File No. March

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2315

**1. PLACE OF DEATH:**

(a) County

(b) City or town St Louis
(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 years, months or days)
In this community

**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

3. (a) PRINT FULL NAME Mary Mayfield

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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 Dec (Month) 25 (Day) (Year)

8. AGE: Years 40 Months 2 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

FATHER
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) 3-8-48 (Date received local registrar) (b) J. F. Bredel (Registrar's signature)

MAR 2 6 1948

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month March 5 year 1948 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 — 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

6753