

S. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15115

State File No. \_\_\_\_\_

FILED APR 29 1948

Registration District No. 322

Primary Registration District No. 4471

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Gilliam  
(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 all his life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline <sup>97</sup>  
(c) City or town Gilliam Mo. <sup>0</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>  
(d) Street No. \_\_\_\_\_ (If rural, give location) <sup>0</sup>  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wm. Payton Mayfield

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 27, 1859  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

12. Name Stephen Mayfield

13. Birthplace Don't know (City, town, or county) (State or foreign country)

14. Maiden name Fricella Bailey

15. Birthplace Don't know (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H.B. Fizer

(b) Address Gilliam Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/48 (Month) (Day) (Year)

(c) Place: burial or cremation Water Cemetery

18. (a) Signature of funeral director Stacy

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

19. (a) 4/12/48 (Date received local registrar) (b) Mrs. Earl C. Metz (Registrar's signature) 7978

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 4 year 1948 hour 12.02 A.M. M.

21. I hereby certify that I attended the deceased from April 1 1948 to April 4 1948; that I last saw him alive on April 4 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia

Due to Prostatic hypertrophy

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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 Dr. M. Barney (Physician or other) Address Stacy Date signed 4/6/48

Duration 4 hrs  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-27-48

APR 27 1948

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 Herman Salzer

Licensed Embalmer No. 1831

P. O. Address Slater 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.