

FILED JUN 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20032

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>7</u>			
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>					
7. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains,</u>		c. LENGTH OF STAY (In this place) <u>16 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains,</u>		0461			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Stoll Surg. Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Missouri Ave.,</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>James Mayfield</u> b. (Middle) <u>Odom</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>5-6-50</u>						
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>6-10-1889</u>			
9. AGE (In years last birthday) <u>60</u>		10. UNDER 1 YEAR Months <u>10</u> Days <u>26</u>		11. UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Flooring Company</u>			11. BIRTHPLACE (State or foreign country) <u>0</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Unk</u>		13b. MOTHER'S MAIDEN NAME <u>UNK</u>		14. NAME OF HUSBAND OR WIFE <u>Stella Odom</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Stella Odom, West Plains, Mo</u>			ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Myocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u> <u>331X</u> <u>3</u>		
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>5/1/50</u> , 19 <u>50</u> , to <u>5/6/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>5/6/50</u> , 19 <u>50</u> , and that death occurred at <u>7:15A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>G. B. Stoll M.D.</u> (Degree or title)					23b. ADDRESS <u>West Plains Mo</u>			23c. DATE SIGNED <u>5/20/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B U</u>		24b. DATE <u>5-9-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains, Mo</u>			
DATE REC'D BY LOCAL REG. <u>6-12-50</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Robertsons, West Plains, Mo</u>			ADDRESS _____	

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

RECEIVED 6-19-50  
District Health Officer No. 5,  
District File Number 650-349  
Date Filed 6-19-50

**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 \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

Student .....  
Student Embalmer

Signed *A. A. Roberts* \_\_\_\_\_

Licensed Embalmer No. *3432* \_\_\_\_\_

P. O. Address *West Ham* \_\_\_\_\_

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.