

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35698

State File No. 8014

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri				c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Quincy, Ill.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				f. STREET ADDRESS (If rural, give location) 936 Madison Avenue				8123			
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)		
			CHARLES		ALLAN		MAYFIELD		August 28, 1954		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		Married		Dec 26 1903		50			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)			12. CITIZEN OF WHAT COUNTRY?		
Clerk				Offical		Jacksonville, Illinois			U.S.A.		
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE			
Charles Mayfield				Olive Johnson				Geraldine Mayfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME ADDRESS					
No			Nil			356-12-0208			Geraldine Mayfield, Quincy, Illinois		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration pneumonia, post-operative						24 hrs.		
			ANTECEDENT CAUSES								
			<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) Sub-arachnoid hemorrhage and intraventricular hemorrhage</p>						48 hrs.		
			<p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p> <p>? Brain tumor</p>								
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?		
8-25-54			as above						YES <input checked="" type="checkbox"/> NO <input 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?			192x		
22. I hereby certify that I attended the deceased from 8-20 , 19 54 , to 8-28 , 19 54 , that I last saw the deceased alive on 8-28 , 19 54 , and that death occurred at 5:00 a.m. , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title)						23b. ADDRESS			23c. DATE SIGNED		
C. J. Verillion, M.D.						BARNES HOSPITAL			8-28-54		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY				24d. LOCATION (City, town, or county) (State)			
Removal		8-28-54		Quincy Memorial Park Quincy, Illinois							
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
AUG 31 1954			J. Earl Smith, M.D.			Albert H. Hoppe			4700 Washington Blvd		

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

(Licensed Embalmer's Statement on Reverse Side)

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 Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *G. W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *W. Lou*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.