

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40223

State File No. ....

FILED DEC 28 1955

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Registrar's No. 1136

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 122 PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give RURAL and give OR TOWN <u>Springfield</u> ) c. LENGTH OF STAY (in this place) <u>19 Days</u>		c. CITY OR TOWN <u>Springfield</u> 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 <u>Burge Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>1663 E. Commercial</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>RENZIE</u>	b. (Middle)	c. (Last) <u>MAYFIELD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 18, 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>25 March 1899</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Groceryman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Albert Mayfield</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Walker</u>	14. NAME OF HUSBAND OR WIFE <u>Elsie Mayfield</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Myocardial insufficiency</u>		<u>1 yr</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>Hypertensive cardio vascular disease</u>  DUE TO (c) _____		<u>3 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>443x</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 4-22-53, 19  , to 12-18-55, 19  , that I last saw the deceased alive on 12-18-55, 19  , and that death occurred at 11:55Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul O. Morton</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>1630 N. Jefferson Springfield, Mo.</u>	23c. DATE SIGNED <u>12-21-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-21-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rock Prairie</u>	24d. LOCATION (City, town, or county) (State) <u>Polk County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>12-21-55</u>	REGISTRAR'S SIGNATURE. <u>Paul Williamson</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Klingner &amp; Co.</u>	ADDRESS <u>Springfield, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 10 1963

REC 29 FEB 63

**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 *Max Phad*.....

Licensed Embalmer No. *40*.....

P. O. Address *Spring*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.