

FILED SEP 9 1957

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

302266

STATE FILE NUMBER

Registration District No. 317Primary Registration District No. 541Registrar's No. 2069

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton, Missouri</u>			c. CITY OR TOWN <u>Clayton</u> <u>44520</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>765 Westwood Drive</u>			d. STREET ADDRESS (If outside, give location) <u>765 Westwood Drive</u>		
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>NMN</u> Last <u>MAYFIELD</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1901</u>	9. AGE (In years last birthday) <u>56</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>4</u> IF 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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Leesburgh, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>W. L. Reid</u>		13b. MOTHER'S MAIDEN NAME <u>Kate Stone</u>		14. NAME OF HUSBAND OR WIFE <u>Lee Mayfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mr. Lee Mayfield 765 Westwood Drive</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>203x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ g.m. _____ p.m. _____ Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>AUGUST 7, 1957</u> to <u>AUG. 15, 1957</u> and last saw ^{her} him alive on <u>AUG. 15, 1957</u> Death occurred at <u>8:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Carl Stein</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>4960 Audubon</u>		22c. DATE SIGNED <u>8/19/57</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8/19/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leesburgh Cemetery</u>		23d. LOCATION (City, town, or county) <u>Leesburgh, Texas</u>
24. FUNERAL DIRECTOR ADDRESS <u>C. R. Lupton & Sons 7233 Delmar</u>			25. DATE RECD. BY LOCAL REG. <u>8-19-57</u>		26. REGISTRAR'S SIGNATURE <u>Robert P. Donohue M.D.</u> <u>arc</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

Arnold W. Schoen

Licensed Embalmer No. *3864*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.