

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

388869

STATE FILE NUMBER

FILED OCT 29 1957

Registration District No. 337 Primary Registration District No. 4499 Registrar's No. 75

Health, Welfare & Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>SHELBY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLARENCE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>CLARENCE</u>		1020 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME CLARENCE MO</u>			Length of stay in 1b <u>60 yrs</u>			d. STREET ADDRESS (If outside, give location) <u>CLARENCE MO</u>	
3. NAME OF DECEASED (Type or print) <u>VERILE ADELENE MAYFIELD</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>2</u> <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</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>JULY 15 1897</u>	
9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		100. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>MO SHELBY COUNTY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>HENRY CHATMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA FRANKLIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>OLLIE MAYFIELD CLARENCE MO</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>Tertiary Syphilis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Primary Syphilis</u> 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>0210</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>10 years</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20d. INJURY OCCURRED WHILE AT WORK <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>June 1953</u> to <u>Oct. 21, 1957</u> and last saw her <u>him</u> alive on <u>Oct. 21, 1957</u> Death occurred at <u>7:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>B.L. Edgington D.O.</u>			(Degree or title)			22b. ADDRESS <u>Clarence, Mo</u>	
22c. DATE SIGNED <u>Oct 23, 1957</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-23-57</u>		<u>CITY CEMETERY</u>		<u>CLARENCE MO</u>	
24. FUNERAL DIRECTOR <u>Chas. V. Sheering</u>				ADDRESS <u>Clarence Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 24-1957</u>	
				26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>			

(Licensed Embalmer's Statement on Reverse Side)

8561 JAN 8 1958

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 *Charles O. Green*

Licensed Embalmer No. *462*

P. O. Address *Claremont*

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.