t. Health,
& Welfare
S. Public
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v. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-019945
STATE FILE NUMBER 3865

FILED JUN 13 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2306 Benton St. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2306 Benton St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Emma Middle Mae Last Mayfield

4. DATE OF DEATH Month Juns Day 4 Year 1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH Feb. 15 1897
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Samuel Hollaman
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Late William Mayfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Del Mayfield Address Godfrey Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerotic Heart Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. 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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 5-9-58 to 6-4-58 and last saw her alive on 6-3-58
Death occurred at 6-4-58 6.20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. P. Berman M.D.
22b. ADDRESS 1225 No. Grand
22c. DATE SIGNED 6-5-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE June 7 1958
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis Co.

24. FUNERAL DIRECTOR ADDRESS Leidner Undertaking 2223 St. Louis Ave.
25. DATE RECD. BY LOCAL REG. JUN 6 '58
26. REGISTRAR'S SIGNATURE J. Earl Smith, MD S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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 Albert Mayfield

Licensed Embalmer No. 3077

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.