

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001727
STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 18

300
-57

1. PLACE OF DEATH a. COUNTY JASPER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JASPER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JOPLIN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN JOPLIN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MOA ST. JOHN'S HOSP.		Length of stay in 1b 3 YRS	d. STREET ADDRESS 3105 1/2 MAIN ST.

3. NAME OF DECEASED (Type or print) First Middle Last GERTRUDE KALMM MAYFIELD			4. DATE OF DEATH Month Day Year JANUARY 4, 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1890		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (City and state or country) KANSAS CITY, KS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME UNK		14. NAME OF HUSBAND OR WIFE WILEY A. MAYFIELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address WILEY A. MAYFIELD, 3105 1/2 MAIN STREET	

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 FATAL			INTERVAL BETWEEN ONSET AND DEATH LESS THAN 30 MIN
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) 4201			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.) PRONOUNCED DEAD AT ST. JOHNS HOSPITAL		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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 _____ DID NOT ATTEND her alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Evelyn M. Merriam		22b. ADDRESS Joplin Mo		22c. DATE SIGNED 1/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 1-7-59		23c. NAME OF CEMETERY OR CREMATORY QUINDARO CEMETERY,	
				23d. LOCATION (City, town, or county) (State) KANSAS CITY, KANSAS	

24. FUNERAL DIRECTOR STEVE PARKER MORTUARY, JOPLIN, MO		25. DATE RECD. BY LOCAL REG. Jan. 7-1959		26. REGISTRAR'S SIGNATURE Dove Merriam	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Josephine 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.