

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007199

FILED VS FEB 16 1960

195

19-60

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <i>McDonald</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>McDonald</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Buffalo</i>	Length of stay in 1b <i>24 years</i>	c. CITY OR TOWN <i>Goodman</i>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Rt 1 Goodman, Mo</i>		d. STREET ADDRESS (If outside, give location) <i>Route 1</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Lillie</i> Middle <i>Pearl</i> Last <i>Mayfield</i>			4. DATE OF DEATH Month <i>Jan.</i> Day <i>29</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>6-16-1885</i>	9. AGE (last birthday) <i>74</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaking</i>	11. BIRTHPLACE (City and state or country) <i>Boyer County, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	

13a. FATHER'S NAME <i>George B. Ruddick</i>	13b. MOTHER'S MAIDEN NAME <i>Katie (Unknown)</i>	14. NAME OF HUSBAND OR WIFE <i>Frank Hill Mayfield</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Frank Hill Mayfield Goodman, Mo.</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Hypertensive Vascular Disease</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) <i>Severely</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Decompensated Heart Disease</i>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ a.m. _____ p.m.	Month, Day, Year _____	

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
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21. I attended the deceased from *3-2-56* to *1-29-60* and last saw her <sup>her</sup> alive on *1-28-60*.  
Death occurred at *4:00 A* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>R. E. Karmack M.D.</i> (Degree or title)	22b. ADDRESS <i>Southwest City, Mo</i>	22c. DATE SIGNED <i>2-8-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Feb 3 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Price Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>McDonald County Missouri</i>
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24. FUNERAL DIRECTOR <i>Koller Funeral Home Goodman, Missouri</i> ADDRESS	25. DATE RECD. BY LOCAL REG. <i>Feb. 8, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mary A. Bradley</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Robert C. Keller

Licensed Embalmer No. 5062

P. O. Address Anderson, N.C.

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.