

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 29 1960

-60-045478

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 5290 Registrar's No. 130

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| 1. PLACE OF DEATH a. COUNTY <u>Plays</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>mo.</u> b. COUNTY <u>Plays</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kearney</u> | Length of stay in 1b <u>2 yrs.</u> | c. CITY OR TOWN <u>Kearney</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RI</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside give location) <u>RI</u> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>TEMP</u> Middle <u>A.</u> Last <u>MAYFIELD</u> | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>60</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>8-24-1890</u> | 9. AGE (last birthday) <u>70</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR. Hours _____ Min. _____ |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u> | 11. BIRTHPLACE (City and state or country) <u>Slater, mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>Steve Mayfield</u> | 13b. MOTHER'S MAIDEN NAME <u>Amanda Dennis</u> | 14. NAME OF HUSBAND OR WIFE <u>Myrtle Mayfield</u> | |

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>495-09-8129</u> | 17. INFORMANT Address <u>Myrtle Mayfield RI Kearney, mo.</u> |
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| 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) <u>Bronchopneumonia</u> | | <u>5 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>pulmonary edema</u> | <u>5 days</u> |
| | DUE TO (c) <u>Bronchogenic carcinoma</u> | <u>4-5 mo</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ |
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| 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 _____ to _____ and last saw ^{her}/_{him} alive on _____
Death occurred at 5:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Wm. R. Morrison, D.D.</u> | 22b. ADDRESS <u>West Kansas, Liberty, Mo.</u> | 22c. DATE SIGNED <u>12-15-60</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-18-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u> | 23d. LOCATION (City, town, or county) (State) <u>Plays Co, mo</u> |
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| 24. FUNERAL DIRECTOR ADDRESS <u>Church-Orchard Co. Liberty, mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>12-17-60</u> | 26. REGISTRAR'S SIGNATURE <u>Mabel Straham</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 30 1980

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 Harold A Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.