

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031841

STATE FILE NUMBER

AMENDED

Registration District No. 032

Primary Registration District No. _____ Registrar's No. 03238

FILED SEP 26 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bollinger</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mayfield</u>		Length of stay in 1b <u>90 yrs</u>	c. CITY OR TOWN <u>Mayfield</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 mi South Mayfield</u>		Inside limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1/2 mi South</u>
3. NAME OF DECEASED (Type or print) First <u>Johnson</u> Middle <u>Mayfield</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22-1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE (last birthday) <u>93</u>
11. BIRTHPLACE (City and state or country) <u>Mayfield, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Elisha Mayfield</u>		13b. MOTHER'S MAIDEN NAME <u>Julia Williams</u>	
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>None</u>	
17. INFORMANT <u>Emory Mayfield</u>		Address <u>Mayfield 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>Hypertensive Myo. Carditis</u> DUE TO (b) <u>Infirmities of old age</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying, cause last.			INTERVAL BETWEEN ONSET AND DEATH
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
19. WAS AUTOPSY PERFORMED? YES <input 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.)	
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 _____
21. I attended the deceased from <u>Jan 1st 1950</u> to <u>Sept 16th 1961</u> and last saw him alive on <u>Sept 10th 1961</u> Death occurred at <u>10 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Edw. Wiles M.D.</u>		22b. ADDRESS <u>Sedgewickville Mo.</u>	22c. DATE SIGNED <u>9/18/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept 18, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pulliam</u>	23d. LOCATION (City, town, or county) (State) <u>Mayfield Mo.</u>
24. FUNERAL DIRECTOR <u>B.G. Miller</u>		25. DATE RECD. BY LOCAL REG. <u>9-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Buford Crader</u>

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 Gene C. Crawford

Licensed Embalmer No. 4327

P. O. Address Jackson, W.

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.