MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

62-000194
STATE FILE NUMBER

AMENDED

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 12

FILED FEB 6 1962

1. PLACE OF DEATH
a. COUNTY: Bollinger
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Mayfield — Length of stay in 1b: Life
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Home — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Bollinger
c. CITY OR TOWN: Mayfield — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): None — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: John Middle: H, Last: Mayfield
4. DATE OF DEATH: Month: Jan Day: 29 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Sep 4, 1873
9. AGE (last birthday): 88 — 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): Farm
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Mayfield, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Elisha E. Mayfield
13b. MOTHER'S MAIDEN NAME: Julia Ann Williams
14. NAME OF HUSBAND OR WIFE: Tilda Seabaugh
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.: Unknown
17. INFORMANT: Dale E. Mayfield, Jackson, Mo (Address)

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): Hypertension - Myo Carditis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): _____
DUE TO (c): _____
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
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 Jan 14th 1960, to Jan 29th 62 and last saw ~~her~~ him alive on Jan ~~29th~~ 26th 1962
Death occurred at 2 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): Edw. Crites M.D.
22b. ADDRESS: Sedgewickville Mo
22c. DATE SIGNED: 1/31/62
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb 1, 1962
23c. NAME OF CEMETERY OR CREMATORY: Sargents Chapel Cem
23d. LOCATION (City, town, or county) (State): Sedgewickville Mo
24. FUNERAL DIRECTOR: S. C. Crawford — ADDRESS: Jackson, Mo
25. DATE RECD. BY LOCAL REG.: 2-3-62
26. REGISTRAR'S SIGNATURE: Mrs Buford Crader

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF	DOCUMENT

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 Mi

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.