

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019559

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. _____ Registrar's No. 85 STATE FILE NUMBER

FILED MAY 24 1962	
1. PLACE OF DEATH a. COUNTY Macon	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Callao	Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. CITY OR TOWN Callao	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HAMILTON MAYFIELD	
4. DATE OF DEATH Month Day Year May 8 1962	
5. SEX Male	6. COLOR OR RACE White
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1870
9. AGE (last birthday) 92	
IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Macon Co. Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James S. Mayfield	13b. MOTHER'S MAIDEN NAME Sarah E. Teter
14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT Hobart Mayfield Address Callao, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Valvular Leakage	
DUE TO (c) Senility	
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 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	
21. I attended the deceased from <u>June 1958</u> to <u>May 8, 62</u> and last saw ^{him} alive on <u>May 8 62</u> . Death occurred at <u>9 AM May 8, 1962</u> m on the date stated above, and to the best of my knowledge from the causes stated.	
22a. SIGNATURE (Degree or title) Charles E. Sharp D.O.	22b. ADDRESS Box 667 Callao, Mo.
22c. DATE SIGNED 5/8/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-11-1962
23c. NAME OF CEMETERY OR CREMATORY Hebron	
23d. LOCATION (City, town, or county) Callao Missouri	
24. FUNERAL DIRECTOR R. Lester Brom ADDRESS Macon, Mo.	25. DATE RECD. BY LOCAL REG. 5/10/62
26. REGISTRAR'S SIGNATURE Cath McNeely	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 R. Lester Bram

Licensed Embalmer No. 4472

P. O. Address Marion, 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.