

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-041567

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 79

FILED NOV 27 1962

VS 300 Rev. 4/59	DATE AMENDED
10090	
2090	
3	
4 1	
5 1	
6	
7 0	
8 0	
94500	
10	
11	
1290-0	
13 1-0	

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mayfield, Mo</u>		Length of stay in 1b <u>8 yrs</u>	c. CITY OR TOWN <u>Mayfield, Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mayfield, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Mayfield, Mo</u>
3. NAME OF DECEASED (Type or print) First <u>Minta</u> Middle <u>E</u> Last <u>Mayfield</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>3/12/1881</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Near Lotosville, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>America</u>		13a. FATHER'S NAME <u>Edward Eaker</u>	
13b. MOTHER'S MAIDEN NAME <u>Catherine Shelton Eaker</u>		14. NAME OF HUSBAND OR WIFE <u>George H. Mayfield</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. _____	17. INFORMANT <u>Perry Mayfield Patton, 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>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>			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>May 1950</u> to <u>11-5-62</u> and last saw her ^{her} _{him} alive on <u>11-4-62</u> Death occurred at <u>3 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E.F. McDonald, MD</u> (Degree or title)		22b. ADDRESS <u>Jackson, Mo.</u>	22c. DATE SIGNED <u>11-10-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Nov 7, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pulliam</u>	23d. LOCATION (City, town, or county) (State) <u>Bollinger County, Mo</u>
24. FUNERAL DIRECTOR <u>A. Craft Jackson, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-20-62</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Buford Crader</u>

DOCUMENT

MEDICAL CERTIFICATION

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

USE BLACK INK OR TYPEWRITER RIBBON

NOV 28 1962

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 *[Handwritten Signature]*

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.