MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21556

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.: 2691

Township: Kau — Primary Registration District No.: 1007 — Registered No.:

City: Kansas City (No.: 4036 Prospect St. Ward)

2. FULL NAME: Mr. Earl Thornton Fielder.

(a) Residence. No.: 8356 Woodland St., C. Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mrs Barbara Rosa Fielder

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 27-1897

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Driver
(b) General nature of industry, business, or establishment in which employed (or employer): City Ice Co.
(c) Name of employer: Route 61. 10 yrs

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Savannah Penn

PARENTS

10. NAME OF FATHER: Wm Warren Fielder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Sicka Miss

12. MAIDEN NAME OF MOTHER: Ida Duncan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Clifton Penn

14. INFORMANT: Mrs Barbara Rosa Fielder
(Address): 8356 Woodland.

15. FILED 6/20, 1931 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1931. Friday

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19, that I last saw him alive on, 19, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental Auto Suicide Fracture skull. 1 hr. No. 7 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Pedestrian

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

6/19, 1931 (Signed) Stanley M. Hall, M. D.
(Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary	6-22 1931
20. UNDERTAKER	**ADDRESS**
Eylar Funeral Home	1800 Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

OCT 10 1940