

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.

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS 791  
CERTIFICATE OF DEATH 1003

723  
Do not use this space.

1. PLACE OF DEATH

(a) County 21 Registration District No. \_\_\_\_\_  
 (b) Township \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. 723  
 (c) City St. Louis (d) Street No. 3964 West Belle Place St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

432 Charles Henry Fields  
 (a) Residence, No. 3964 West Belle Place St. 11  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mabel Fields

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 28, 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
61 10 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Waiter  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mason City Tennessee

FATHER 13. NAME Charles Fields

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (NAME) Mabel Fields  
 (ADDRESS) 3964 West Belle Place

18. BURIAL, CREMATION, OR REMOVAL PLACE Alton, Ill. DATE Jan. 25, 1939

19. FUNERAL DIRECTOR (NAME) Russell Undt. Co.  
 (ADDRESS) 2732 Pine Street

20. FILED J. B. Budak  
 Local Registrar.

JAN 24 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/26, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1/20/39 to 1/26/39, 1939  
 I last saw him alive on 1/20/39 at 6:30 P.M. Death is said to have occurred on the date stated above, at 6:30 P.M.

The principal cause of death and related causes of importance were as follows:

Apoplexy  
82  
 Other contributory causes of importance: Hypertension

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? 220  
 If so, specify \_\_\_\_\_  
 (Signed) J. C. Hill, M. D.  
 (Address) 7105 7/ Sarah

Faint header text, possibly including "STATE OF TEXAS" and "DEPARTMENT OF HEALTH".

**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,

Joel Russell

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Joel Russell*

Licensed Embalmer No.

2115

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**