

1939 OCT 13 1939

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

33696
Do not use this space.

1. PLACE OF DEATH

(a) County Stoddard Registration District No. 888
(b) Township Liberty Primary Registration District No. 609813 Registered No.
(c) City (d) Street No.
(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 Christopher Columbus Fields
(a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 21/39 19

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

22. I HEREBY CERTIFY, That I attended deceased from July 1 1939, to Sept. 21 1939.
I last saw him alive on Sept. 15 1939. Death is said to have occurred on the date stated above, at 1:15 am.
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
85 1 0

Other contributory causes of importance:
Septicemia from Chronic cystitis

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
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.....

137
Hypertrrophic prostate Genuerity

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

Name of operation Date of
What test confirmed diagnosis? Clinical Was there an autopsy? no

FATHER 13. NAME Wiley Fields

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

MOTHER 15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record

17. INFORMANT (ADDRESS) A. L. Thrower Dexter, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE C. Dowdy Cem DATE 9/22/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Blankenship-Strickland Dexter, Mo.

20. FILED 90/15 1939 Jessie Burton Local Registrar.

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? no
If so, specify (Signed) Frank Kubie, M. D.
(Address) Dexter Mo.

RECEIVED

District Health Officer No. 2,

District File Number 1039-266

Date Filed 10-11

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

J. J. Stuckert, Registered-Apprentice No. _____
working under my personal supervision.

Signed J. J. Stuckert
Licensed Embalmer No. 3479

P. O. Address West, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

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