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V. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8975

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2458

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County
(c) City or town Newton N.R.
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME CHARLES ALBERT FIELD

3. (b) If veteran, name war Unknown
3. (c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Otilda
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct. (Month) 10 (Day) 1865 (Year)

8. AGE: Years 74 Months 5 Days 3 If less than one day hr. min.

9. Birthplace Effingham Co. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Creamery Employee

11. Industry or business

FATHER
12. Name Nelson Field
13. Birthplace Effingham Co. (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Sarah Layton
15. Birthplace Effingham Co. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Irl Field
(b) Address Newton, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-15-40 (Month) (Day) (Year)
(c) Place: burial or cremation Dietrich, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) MAR 13 1940 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13 year 1940 hour 3 minute A M.

21. I hereby certify that I attended the deceased from February 22, 1940, to March 13, 1940, that I last saw him alive on March 13, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho pneumonia - Terminal	48 hrs
Due to: Adeno carcinoma of cecum	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Jane B. Harkloff M.D. (M. D. or other)
Address BARNES HOSPITAL Date signed 3-13-40

(Licensed Embalmer's Statement on Reverse Side)

Ona.

Hoppe

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

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.