

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

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED NOV 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36550

State File No. _____

Registration District No. 837

Primary Registration District No. 6099

Registrar's No. 6099

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Bloomfield, Mo.
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community Years
years, months or days

3. (a) PRINT FULL NAME Bell Fairfield
3. (c) Social Security No. _____
3. (b) If veteran, name war _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife J. S. Fairfield 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 1, 1865
(Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Soloman W. Hobgood

13. Birthplace South Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Carr

15. Birthplace South Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant J. W. Hobgood

(b) Address Bloomfield, Missouri

17. (a) Burial (b) Date thereof Oct. 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Zion Cemetery

18. (a) Signature of funeral director Chiles Und. Co.
(b) Address Bloomfield, Mo.

19. (a) Oct-26-1940 (b) Spornie Lurch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Bloomfield, Mo. * Route
(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from JUNE 18, 1940 to OCT. 2, 1940
that I last saw her alive on OCT. 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death SENILE DEBILITY
CHRONIC MYOCARDITIS (NOT RHEUMATIC)
ASTHMA (BRONCHIAL)
Other conditions ARTERIOSCLEROSIS (GENERAL)
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

865 (Specify type of place) _____
While at work? _____ (c) Means of injury _____
23. Signature [Signature] or (by other) DO.
Address BLOOMFIELD Date signed 10-24-40

RECEIVED

District Health Officer No. 2,

District File Number 140-1691

Date Filed 11/12/40

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 Deceased was not embalmed.

Licensed Embalmer No.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36530

Registration District No. 837

Primary Registration District No. 6099

Registrar's No. _____

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Custar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Bell Fairfield

3. (b) If veteran, _____ (c) Social Security
name war _____ No. _____

4. Sex 7

5. Color or race w

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 6 3 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) Oct 26 '40 (b) Boonie Cunch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 4th
year 1940 hour 2 minute 30 P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. S. Davenport (M. D. or Other)
Blountfield Date signed _____

SUPPLEMENTARY

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

