

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 35

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

1. PLACE OF DEATH  
(a) County Adair  
(b) City or town Keokuk  
(c) Name of hospital or institution: Green & Smith Hospital  
(If not in hospital of institution, write street number or location)  
(d) Length of stay: In hospital or institution 1/2 day  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Marion Wilson Fields  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June 18, 1914  
(Month) (Day) (Year)

8. AGE: Years 26 Months 7 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmers

11. Industry or business General Farming

12. Name Marion Jacob Fields

13. Birthplace Sullivan Co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Alice Shepherd

15. Birthplace Sullivan Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Chloe Fields  
(b) Address Millars Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1941  
(Month) (Day) (Year)

(c) Place: burial or cremation Spring  
18. (a) Signature of funeral director Schwenker  
(b) Address Millars Mo.

19. (a) Jan. 31/40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Sullivan  
(c) City or town Millars (Rural)  
(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 July day 28  
year 1941 hour 17 minute 40 M.  
21. I hereby certify that I attended the deceased from July 28, 1941, to July 28, 1941,  
that I last saw him alive on July 28, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage from bowel  
Due to Chr. Nephritis  
Duration 1 day

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 12/10

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? \_\_\_\_\_

23. Signature Al Schwenker (M. D. or other) \_\_\_\_\_  
Address Keokuk Mo Date signed 1-25-41  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_

RECEIVED

District Health Officer No. 10

District File Number 2-41388

Date Filed FEB 19 1941

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.....

Frank D. Schoene Registered Apprentice No.....  
working under my personal supervision.

Signed

Frank D. Schoene

Licensed Embalmer No. 2016

P. O. Address Milwaukee, Wis.

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.