S. No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7910

FILED MAR 19 1943

Registration District No. 226 Primary Registration District No. 6209 Registrar's No. 4

106
0
0

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

1. PLACE OF DEATH:

(a) County TEXAS

(b) City or town RURAL PINEY TWP
(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 72 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 106

(a) State MO (b) County TEXAS 0

(c) City or town RURAL
(If outside city or town limits write "RURAL")

(d) Street No. 5 MI. W. HOUSTON, MO
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JAMES MADISON FIELDEN

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED /

6. (b) Name of husband or wife MARY E. FIELDEN 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased JUNE (Month) 24 (Day) 1870 (Year)

8. AGE: Years 72 Months 7 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace TEXAS CO. (City, town, or county) MO (State or foreign country) 0

10. Usual occupation FARMER

11. Industry or business J

FATHER
12. Name JOHN FIELDEN
13. Birthplace UNKNOWN (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name SALLIE COATS
15. Birthplace TEXAS CO (City, town, or county) MO (State or foreign country) 0

16. (a) Informant Wm. F. FIELDEN
(b) Address LAJAUNTA, COLO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/11/43 (Month) (Day) (Year)
(c) Place: burial or cremation FREELY GIVE

18. (a) Signature of funeral director Gaylord V. Elliott
(b) Address HOUSTON, MO

19. (a) Feb. 15-43 (Date received local registrar) (b) Mrs. Ella Duff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 9
1943 year 12 hour _____ minute _____ A.M.

21. I hereby certify that I attended the deceased from MAY 10, 1937, to FEB 9, 1943
that I last saw him alive on FEB 8, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	
Due to HYPERTENSIVE CARDIO-RENAL-VASCULAR	
Due to DISEASE	
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 L. M. Dillman (M. D. or other) M.D.
Address Houston Mo Date signed 2-10-43

1240

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Center No 5
District File Number 343152
Date Filed 8-3-49

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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, Mo

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

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