

Registration District No. 268

Primary Registration District No. 5906

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town Little River Rural
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot
(c) City or town Rural
(d) Street No. Little River township
(e) If foreign born, how long in U. S. A. 1 years

3. (a) PRINT FULL NAME Walter Fields

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

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

6. (b) Name of husband or wife Celia Fields 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased 6 10 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business Cotton farmer

12. Name Walter Fields

13. Birthplace Triply Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Shirley Moore

15. Birthplace Triply Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Celia Fields

(b) Address Wardell, Mo.

17. (a) Burial (b) Date thereof 4 11-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wardell, Mo.

18. (a) Signature of funeral director F. J. Smith

(b) Address Fayh, Mo.

18. (a) _____ (b) _____
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 4
year 1943 hour 9 minute A.M.

21. I hereby certify that I attended the deceased from March 25, 1943, to April 1st, 1943; that I last saw him alive on April 1st 43, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic endocarditis with valvular insufficiency and regurgitation
Due to Rheumatism

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy No

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 H. H. Reicher (M. D. or other) _____
Address Portageville, Mo. Date signed _____

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

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

4-43-189

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.....

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15066

Registration District No. 268

Primary Registration District No. 5906

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Platteau

(b) City or town Rural
(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

3. (a) PRINT FULL NAME Walter Fields

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

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

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

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

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 4 5 49 (b) J.R. [Signature]
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr Day 3 Year 1943 hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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? _____

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

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

S-15066