

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Masonic Home of Missouri 5  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 yrs.  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jeremiah Fields

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or Grace W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Elizabeth McKnight

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 3, 1857  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>10</u>	<u>11</u>	hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Stephen Fields

13. Birthplace Ray County, Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Miriam McDonald

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

16. (a) Informant Masonic Home

(b) Address 5351 Delmar Ave.

17. (a) Removal (b) Date thereof 1-17-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Henrietta Mo.

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Blvd

19. (a) JAN 17 1944 (b) J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 5351 Delmar Blvd  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17th  
year 1944 hour 2:15 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from December 15th, 1936 to January 17, 1944, that I last saw him alive on January 16th, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 6 mos.

Due to Senility 1 yr.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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 Blon Fawcett (M. D. or other) \_\_\_\_\_

Address 508 N. Grand Date signed Jan 17, 1944

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2  
43  
39  
235697

**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

*Albert Hoppe*  
1861

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, fact should be so stated above.**