

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20991

State File No. \_\_\_\_\_

DEAD JUL 11 1945  
Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 54

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

1. PLACE OF DEATH:

(a) County Pemiscot

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

(c) Name of hospital or institution:  
Edwards Addition  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 40 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot

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

(d) Street No. Edwards Addition  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CARROLL DOYLE FIELDS

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 9<sup>TH</sup>  
year 1945 hour 2 minute 20 P. M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Edna Tims-Fields

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Feb. 9 1880  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 21, 1945, to June 9, 1945; that I last saw him alive on June 9, 1945; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

<u>65</u>	<u>4</u>	<u>0</u>	hr. _____ min. _____
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Immediate cause of death Carcinoma of L. Lung

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

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

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

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

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

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

10. Usual occupation Merchant

11. Industry or business Retired

MOTHER FATHER { 12. Name John T. Fields

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

14. Maiden name Lucy Jennings

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

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? \_\_\_\_\_

16. (a) Informant Mrs. S. D. Fields

(b) Address Caruthersville, Mo.

17. (a) Burial (b) Date thereof 6/11/1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. Smith Funeral Home

(b) Address Caruthersville, Mo.

19. (a) 6-12-1945 (b) Jessie N. Markey  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature J. J. Quinn, W.P. (M. D. or other)

Address Caruthersville, Mo. Date signed 6-12-45

Duration ?

PHYSICIAN

Underline the cause to which death should be charged statistically.

6-45-141

**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, fact should be so stated above.**