

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED DEC 13 1945

Primary Registration District No. **1003**

Registrar's No. **10328**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
17
9
MOTHER FATHER
Joe Fields
Sara Fields

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:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Lucille Wellington

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Female 5. Color or race Col.

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

6. (b) Name of husband or wife Lee Wellington

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

7. Birth date of deceased: August 4 1904
(Month) (Day) (Year)

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

41	3	1	hr. _____ min. _____
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9. Birthplace: Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business _____

12. Name: Joe Fields

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

14. Maiden name: Sara Fields ?

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

16. (a) Informant: Elizabeth Hardiman
2601 N Whittier St.

(b) Address _____

17. (a) Burial (b) Date thereof: NOV 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: CITY CEMETERY

18. (a) Signature of funeral director: J. B. Hudson
City Health Dept

(b) Address _____

19. (a) NOV 29 1945 (b) J. J. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 3319 Delmar
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5
year 1945 hour 5 minute 25 A. M.

21. I hereby certify that I attended the deceased from Oct. 27 1945 to Nov. 5 1945
that I last saw her alive on Nov. 5 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Glomerulonephritis
Uremia

Due to _____

Due to _____

Other conditions: Multinodular Thyroid
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy: Yes

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: J. B. Bernard (M. D. or other) _____
Address: 2601 N Whittier Date signed: 11/29/45

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.