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7. 5-17-39
WI X35897

42315

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 268

FILED JAN 11 1945
Registration District No. 316

Primary Registration District No. 3061

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

1. PLACE OF DEATH:

(a) County St. Francois

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

(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 _____ (Specify whether _____)
In this community years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Francois 94.

(c) City or town Flat River 5
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 2

(e) Citizen of foreign country? NO. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Gillian E. Fields

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16. 1945 year hour _____ minute 1.00 M.

21. I hereby certify that I attended the deceased from Dec 1 1945 to Dec 16 1945
that I last saw her alive on 14 and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Wm. M. Fields 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Feb 5 1870
(Month) (Day) (Year)

Immediate cause of death branchiopneumonia

Duration _____

8. AGE: Years Months Days If less than one day
75 10 11 hr. _____ min.

Due to _____

Due to Pneumonia

Other conditions (include pregnancy within 3 months of death) _____

9. Birthplace Ill. (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation House work

Major findings: Of operations _____ Of autopsy 107

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

MOTHER FATHER {

12. Name Ralla Surman

13. Birthplace not known 9 (City, town, or county) _____ (State or foreign country) _____

14. Maiden name not known

15. Birthplace not known 9 (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Wm. M. Fields

(b) Address Flat River Mo.

17. (a) Burial (b) Date thereof 12 18 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation wood bury

18. (a) Signature of funeral director Caldwell Bate

(b) Address Flat River Mo.

19. (a) 12-28-45 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

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 N. O. Gault (M. D. or other) _____
Address Alexia Date signed 12-18-45

1397

RECEIVED

District Health Officer No. 4

District File Number 146-1560

Date Filed 1-9-46

FEB 4 1946

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 Geo R. Baldwin

Licensed Embalmer No. 2531

P. O. Address Flat River mo

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.