

No. 2
-8-43
5-17-39
I X37823

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2616

State File No. _____

FILED FEB 4 1946
Registration District No. _____

Primary Registration District No. 4186

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Franklin

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

(c) Name of hospital or institution:
NORTH SIDE HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 DAYS (Specify whether)

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County FRANKLIN ³⁶

(c) City or town ROBERTS VILLE ⁰
(If outside city or town limits, write "RURAL")

(d) Street No. ROUTE 1 ⁰
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Joseph Ward Fields

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race W

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

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

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Sept 28 1866
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>3</u>	<u>9</u>	hr. min.

9. Birthplace Franklin Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business _____

12. Name Charles Fields

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

14. Maiden name Emma Wood

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

16. (a) Informant Elizabeth Field

(b) Address Robertsville Mo.

17. (a) Burial (b) Date thereof Jan 9-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation cedary house

18. (c) Signature of funeral director Cassey Lowry

(b) Address St. Clair Mo.

19. (a) 1-8-46 (b) Chapman
(Date received local registrar) (Registrar signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1946 hour 11 minute 56 P

21. I hereby certify that I attended the deceased from Jan 6 1946 to Jan 6 1946
that I last saw him alive on Jan 6 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia ^{6 days}

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy 108

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 Chapman (M: D: or other) _____
Address Dr. Chapman Mo Date signed 1-8-46

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

556

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-2-46

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 H. M. Lerot
Licensed Embalmer No. 3601
P. O. Address St. Clair, 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.