

No. 2
M-5-43
5-17-39
I X36871

FILED MAR 28 1946

Registration District No. **27**

Primary Registration District No. **3056**

1. PLACE OF DEATH:

(a) County **Randolph**

(b) City or town **Moberly**

(c) Name of hospital or institution: **Buchanan St.**

(d) Length of stay: In hospital or institution **year**

In this community **year**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo**

(b) County **Randolph**

(c) City or town **Moberly**

(d) Street No. **No. Buchanan**

(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Fred L. Hatfield**

3. (b) If veteran, name war **-**

3. (c) Social Security No. **-**

4. Sex **M.** 5. Color or race **W.**

6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Eunice Hatfield**

6. (c) Age of husband or wife if alive **about 70** years

7. Birth date of deceased **June 17 - 1883**

8. AGE: Years **60** Months **6** Days **28**

If less than one day **-** hr. **-** min.

9. Birthplace **Akshahuman**

10. Usual occupation **Steel bar worker**

11. Industry or business **Dent**

12. Name **Dent Know**

13. Birthplace **Dent Know**

14. Maiden name **Dent Know**

15. Birthplace **Dent Know**

16. (a) Informant **Bevil Patrick**

(b) Address **1322 Hwy. Moberly**

17. (a) **Burial**

(b) Date thereof **12-17-46**

(c) Place: burial or cremation **Huntsville**

18. (a) Signature of funeral director **B. E. Hopper**

(b) Address **Blaine Mo.**

19. (a) **Jan 17-46**

(b) **Deah Williams**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY** day **15**

year **1946** hour **6** minute **45 AM**

21. I hereby certify that I attended the deceased from **JAN 14**

19 **46** to **JAN 15** 19 **46**

that I last saw him alive on **JAN 14** 19 **46**

and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Bronchial Pneumonia**

Due to **Bronchial Asthma**

Duration **36 hr**

Due to **-**

Duration **3 yr**

Other conditions **-**

Major findings: **107**

Of operations **-**

Of autopsy **-**

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 **B. E. Hopper**

Date signed **1-16-46**

Address **203 1/2 Malvern, Moberly Mo.**

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

RECEIVED

Health Officer No. 10

Sanitary File Number 3-46-369

Date Filed MAR 7 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.....

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.