

FILED AUG 26 1947
Registration District No. **1001**

Primary Registration District No. **1001**

Registrar's No. **3509**

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

1. PLACE OF DEATH:
Jackson
 (a) County.....
 (b) City or town..... **Kansas City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **General Hospital No. 10**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... **10 days**
 (Specify whether
 In this community..... **28 yrs -**
 years, months or days)

3. (a) PRINT FULL NAME **Charles Lee Fields**
3. (b) If veteran, **no**
3. (c) Social Security No. **486-07-3039**
 name war.....

4. Sex **male** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mabel Fields**
6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **Mar 6 1890**
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
57	5	7	hr. min.

9. Birthplace **Ky**
 (City, town, or county) (State or foreign country)

10. Usual occupation **With Arman & Co.**

11. Industry or business **Veteranary Dept**

12. Name **Stephens Fields**

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

14. Maiden name **No Record**

15. Birthplace **No Record**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mabel Fields**

(b) Address **Mills Mo.**

17. (a) Burial, cremation, or removal **Burial**
(b) Date thereof **Aug 15-47**
 (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Cn.**

18. (a) Signature of funeral director **Mr C.R. Foster**

(b) Address **918 Brooklyn**

19. (a) Date received local registrar **8-15-47**
(b) Registrar's signature **Alvordine Holmes**

2. USUAL RESIDENCE OF DECEASED:
 (a) State..... **Missouri** (b) County..... **Jackson** **48**
 (c) City or town..... **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No..... **3812 E. 37 St.**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **13**
 year **1947** hour **8** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Aug. 3** 19**47** to **Aug. 13** 19**47**
 that I last saw h..... alive on **Aug. 13** 19**47**
 and that death occurred on the date and hour stated above. **Duration**

Immediate cause of death.....
Brain tumor
malignant

Due to.....
 Due to.....

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

Major findings:
 Of operations..... **54 lb**

Of autopsy..... **See above**

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?.....
 (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature **John W. Hart** (M. D. or other) **MD**
Med. Dir. Gen'l Hosp. **8-14-47**
 Address..... Date signed.....

PHYSICIAN

Underline the cause of which death should be charged statistically.

Dr. McDonnell

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 *Cortland Mince*

Licensed Embalmer No. *3414*

P. O. Address *918 Brooklyn*

Kansas City
Missouri

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.