

FILED DEC 6 398

1003

Registrar's No. 10093

Registration District No. ....

Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County.....

(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 G. Phillips Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 2 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....

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

(d) Street No..... 1120 N 19th St.  
(If rural, give location)

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

3. (a) PRINT FULL NAME..... George Field (Bloomfield)

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

4. Sex..... Male 5. Color or race..... Col

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

6. (b) Name of husband or wife..... single 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... Dec. 25 1879  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Nov. day..... 7  
year..... 1947 hour..... 11 minute..... 25 P..... M.....

21. I hereby certify that I attended the deceased from.....  
Nov. 5, 1947, to..... Nov. 7, 1947,  
that I last saw h..... live on..... Nov. 7, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Congestive Heart Failure  
Duration..... Undet.

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>10</u>	<u>12</u>	..... hr. .... min

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

10. Usual occupation..... Unknown

11. Industry or business.....

12. Name..... Unknown

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

14. Maiden name..... "

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

16. (a) Informant..... Elizabeth Rhodes

(b) Address..... 2601 N Whittier St

17. (a) Anatomical Board (b) Date thereof..... DEC 1 - 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Anatomical Board

18. (a) Signature of funeral director..... Hof Rowland

(b) Address..... 435 1/2 Washington

19. (a) DEC 1 1947 (b) J. J. Brebeck  
(Date received local registrar) (Licentiate's signature)

Due to.....

Due to.....

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

Major findings:  
Of operations.....

Of autopsy..... None

PHYSICIAN

Underline the cause of 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..... Oscar L Daniels (M. D. or other).....

Address..... 2601 N Whittier Date signed..... 11/10/47

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

MOTHER FATHER

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**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.