

No. 2  
-1/47  
17-39

10920

FEDERAL SECURITY AGENCY

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. 878

FILED APR 14 1948  
Registration District No. 397

Primary Registration District No. 3066

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Kirkwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution U.S. Marine Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town University City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 7362 Carleton Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES W. FIFIELD.

3. (b) If veteran, name war 1st W. W. 3. (c) Social Security No. 488-01-5412.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Leola G. Fifield 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased June 28 1896  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>9</u>	<u>4</u>	hr. min.

9. Birthplace Amsterdam, New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Retail Jeweler.

11. Industry or business (self).

12. Name Charles H. Fifield.

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

14. Maiden name Robertine Scribner.

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

16. (a) Informant Clinical Records.

(b) Address U.S. Marine Hospital, Kirkwood, Mo

17. (a) Interment. (b) Date thereof 4/5/48.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery.

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address #7233 Delmar Blvd.,

19. (a) 4-6-48 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2nd day April  
year 1948 hour 7:20 minute P. M.

21. I hereby certify that I attended the deceased from March 19th, 1948 to April 2, 1948.  
that I last saw him alive on April 2, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Edema  
Rheumatic Heart Disease  
Myocardial Infarction - 6 yrs.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Cholecystitis, and Cholelithiasis  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy Same as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) X

(b) Date of occurrence X

(c) Where did injury occur? X  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? X  
(Specify type of place)  
While at work X Means of injury \_\_\_\_\_

23. Signature John R. Kelsey M.D.  
U.S. Marine Hospital,  
Address Kirkwood, Mo. Date signed 4/3/48

Duration 30 min.  
Over 2 yrs.  
Unknown  
PHYSICIAN  
Underline the cause of which death should be charged statistically.

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

See Book, Medical In Temporary Charge

APR 4  
APR 22 1948  
MAY 4  
1948

APR 14 1948

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 Arnold W. Schoene  
Licensed Embalmer No. 3864  
P. O. Address St. Louis, 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.