

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 14 1950

State File No. 24544
Registrar's No. 6736

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	State File No. 24544	
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1405 a N. Leffingwell Ave.		STREET ADDRESS (If rural, give location) 1405 a N. Leffingwell Ave.		0	
3. NAME OF DECEASED (Type or Print) Lonnie		a. (First)	b. (Middle) Bearfield	c. (Last)	
4. DATE OF DEATH 8 3 1950		5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 5, 1895		9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing House		11. BIRTHPLACE (State or foreign country) Panola County, Miss.	
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Murphy Bearfield		13b. MOTHER'S MAIDEN NAME Callie Pope	
14. NAME OF HUSBAND OR WIFE Rosie Bearfield		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 487-14-1763	
17. INFORMANT'S SIGNATURE OR NAME Rosie Bearfield		ADDRESS 1405 a N. Leffingwell Ave		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS		*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HHBX	
22. I hereby certify that I attended the deceased from 6-19 1950 to 8-3-1950 , that I last saw the deceased alive on 7-29-1950 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE Robert M. Scott, M.D.		23b. ADDRESS 2007 Easton Ave		23c. DATE SIGNED 8/5/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-9-1950		24c. NAME OF CEMETERY OR CREMATORY BATESVILLE	
24d. LOCATION (City, town, or county) (State) Miss.		DATE REC'D BY LOCAL REG. AUG 8 1950		REGISTRAR'S SIGNATURE J. B. Pasater	
25. FUNERAL DIRECTOR'S SIGNATURE ELLIS FUNERAL HOME, INC., 2820 Stoddard St.		ADDRESS			

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Fred E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address *St Louis 13 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.