

FILED AUG 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23266

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 5568 Registrar's No. 308

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Blue Township RURAL		c. LENGTH OF STAY (in this place) 50 yrs.	c. CITY OR TOWN Blue Township
d. FULL NAME OF HOSPITAL OR INSTITUTION 614 Brookside Drive		f. STREET ADDRESS (If rural, give location) 614 Brookside Drive	
		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) ROSCOE	b. (Middle) C.	c. (Last) FIELDS	(Month) Aug.	(Day) 1	(Year) 1954

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4, 1886	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office	10b. KIND OF BUSINESS OR INDUSTRY Mt. Washington Cem.	11. BIRTHPLACE (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Fields	13b. MOTHER'S MAIDEN NAME Lucy Connor	14. NAME OF HUSBAND OR WIFE Edith Fields
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 486-03-3735	17. INFORMANT'S SIGNATURE OR NAME Mrs. Edith Fields, 614 Brookside Dr. Intercity	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cocciuria trachomatis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atelectasis, Ventilation DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4200	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:20 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edith Fields, Intercity, Missouri	23b. ADDRESS 4050 Brookside Dr. Intercity	23c. DATE SIGNED 8-2-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-5-54	24c. NAME OF CEMETERY OR CREMATORY Mt. Washington	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 8-4-54	REGISTRAR'S SIGNATURE James A. Daley	25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.	ADDRESS K.C.MO.
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(Licensed Embalmer's Statement on Reverse Side)

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

AUG 13 1954

MAY 3 1955

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.....
Signature of Student Embalmer

Signed *J. T. Crowell*.....

Licensed Embalmer No. *49*.....

P. O. Address *H.C. 9th*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.