

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43569**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11950**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis, | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.) | | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN University City, Mo. <input checked="" type="checkbox"/> d. Is Residence within limits of a city or incorporated town? <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital | | STREET ADDRESS (If rural, give location) 8005 Washington Blvd. | |

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|-------------------------------------|--------------------------|-----------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Grover | b. (Middle) C. | c. (Last) Fielder | 4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1954 |
|-------------------------------------|--------------------------|-----------------------|--------------------------|--|

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|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Feb. 2, 1889 | 9. AGE (In years last birthday) 65 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours Min. |
|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|-----------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter | 10b. KIND OF BUSINESS OR INDUSTRY Painting | 11. BIRTHPLACE (City and State or Foreign Country) Salem, Illinois, | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Tilman Fielder | 13b. MOTHER'S MAIDEN NAME Esther Finn | 14. NAME OF HUSBAND OR WIFE Ruth Fielder |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Nil. | 17. INFORMANT'S SIGNATURE OR NAME Ruth Fielder | ADDRESS 8005 Washington Blvd. |
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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, assthenia, 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) Posterior myocardial Infarction | | 10 days |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. occlusion of Rt. coronary art. | | 10 days |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 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) 4201 |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from ~~Nov~~ **1952**, to **12-31, 1954**, that I last saw the deceased alive on **12-30, 1954** and that death occurred at **6:15 A.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Arthur K. Jurske, M.D. | 23b. ADDRESS 1880. Kimpfphway | 23c. DATE SIGNED 12-31-54 |
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|--|---------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 12-31-54 | 24c. NAME OF CEMETERY OR CREMATORY ---- Local | 24d. LOCATION (City, town, or county) (State) Chicago, Illinois, |
|--|---------------------------|--|---|

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| DATE REC'D BY LOCAL REG 12-31-54 | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe | ADDRESS 4700 Washington. |
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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.....
Signature of Student Embalmer

Signed *Geo. W. Wilkerson*

Licensed Embalmer No. *35*

P. O. Address *Mt. Pleasant*

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.