

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16615
4404
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 53-days	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital		STREET ADDRESS (If rural, give location) 17 3644 Shaw Blvd. 2179	

3. NAME OF DECEASED (Type or Print) a. (First) Virginia b. (Middle) Ethel c. (Last) Fields			4. DATE OF DEATH (Month) (Day) (Year) May 18, 1955			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Jan. 17, 1889	9. AGE (In years not birthday) 66	IF UNDER 1 YEAR Months 4 Days 1	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sten. St. Louis Cooperage Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Point Pleasant, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James B. Fields		13b. MOTHER'S MAIDEN NAME Mary Louise Delisle		14. NAME OF HUSBAND OR WIFE	
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 488-61-0076		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Margaret Fields, 3644 Shaw Blvd.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 3 months ago
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pneumonia</i>		DUE TO (b) <i>Unknown</i>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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? 7041

22. I hereby certify that I attended the deceased from 3/15/55, to 5/19/55, 1955, that I last saw the deceased alive on _____, 1955, and that death occurred at 1:45 PM, from the causes and on the date stated above.

23a. SIGNATURE <i>O.D. Fisher</i> (Degree or title)	23b. ADDRESS 18 S. Kings Highway	23c. DATE SIGNED 5/19/55
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE May 19, 1955	24c. NAME OF CEMETERY OR CREMATORY Portageville Cemetery	24d. LOCATION (City, town, or county) (State) Portageville, Mo.
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DATE REC'D BY LOCAL REG. MAY 19 1955	REGISTRAR'S SIGNATURE <i>J. Earl Smith</i>	FUNERAL DIRECTOR'S SIGNATURE <i>J. Donnell</i>	ADDRESS 3840 Lindell Blvd.
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WRITE PLAINLY—USING UNFADING 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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed [Signature]

Licensed Embalmer No 96

P. O. Address 3840th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.