

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>St. Louis</u> |  | c. CITY OR TOWN<br><u>St. Louis</u>   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>                        |  | e. STREET ADDRESS (If rural, give location)<br><u>4136a. St. Louis</u>  | <u>2110</u>   |

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| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>George</u><br>b. (Middle) <u>A.</u><br>c. (Last) <u>Fields</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>3 31 56</u> |
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|-----------------|------------------------------|--|---------------------------------------|---|------------------------|-----------------------------|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u> | 8. DATE OF BIRTH <u>Feb. 28, 1897</u> | 9. AGE (In years last birthday) <u>59</u> | 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)<br><u>Interior Decorator</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Miss.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Philip Fields</u> | 13b. MOTHER'S MAIDEN NAME <u>Savannah</u> | 14. NAME OF HUSBAND OR WIFE <u>Esther Fields</u> |
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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) | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Esther Fields</u> | ADDRESS <u>4136A St. Louis</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis.</u>   |  | <u>Undt.</u>                     |
|  | ANTECEDENT CAUSES  |  |                                  |
|  | *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  |                                  |
|  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.   |  |                                  |
|  | DUE TO (b)   |  |                                  |
|  | DUE TO (c)   |  |                                  |
|  | 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 <u>332x</u> | 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) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 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 3-23-, 1956, to 3-31-, 1956, that I last saw the deceased alive on 3-31-, 1956 and that death occurred at 10:45p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>E. B. Williams</u><br><u>M.D.</u> | 23b. ADDRESS <u>2601 N. Whittier Street</u> | 23c. DATE SIGNED <u>4-2-56</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u> | 24b. DATE <u>4-6-56</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Dak. Date</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u> |
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| DATE REC'D BY LOCAL REG. <u>APR 4 1956</u> | REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Beal</u> | ADDRESS <u>4303 Delmar</u> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 *James C. Hughes*

Licensed Embalmer No. *486*

P. O. Address *4415 a*

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.