

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31846  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4063

1000  
-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Cass</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Harrisonville</i>
c. FULL NAME OF THE NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Research Hosp.</i>		Length of stay in 1b <i>8 weeks</i>	d. STREET ADDRESS (If outside, give location) <i>R.R. 1</i>
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <i>Bert</i> Middle <i>F.</i> Last <i>Fields</i>			4. DATE OF DEATH Month <i>Aug</i> Day <i>29</i> Year <i>1957</i>			
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 1886</i>	9. AGE (In years) Last birthday <i>71</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>farm</i>	11. BIRTHPLACE (City and state or country) <i>Emporia, Kansas</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
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13a. FATHER'S NAME <i>Thomas Fields</i>	13b. MOTHER'S MAIDEN NAME <i>Ruby Barton</i>	14. NAME OF HUSBAND OR WIFE <i>Ada Lee Fields</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>490-42-1982</i>	17. INFORMANT <i>Mrs Bert Fields, Harrisonville, Mo</i>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pulmonary Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
DUE TO (b) <i>Bi Obstructive Pyelonephritis</i>		<i>2 wks</i>
DUE TO (c) <i>Abdominal Carcinomatosis</i>		<i>3 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Primary Adenocarcinoma of Trans. Colon</i>		

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>153x</i>
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20c. TIME OF INJURY Hour <i>1:25 P.</i> Month <i>8</i> Day <i>29</i> Year <i>1957</i> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>Harrisonville</i>	COUNTY <i>Mo.</i>	STATE
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21. I attended the deceased from <i>1955</i> to <i>8/29/57</i> and last saw her alive on <i>8/29/57</i> Death occurred at <i>1:25 P.</i> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <i>G.R. Remhardt M.D.</i>	22b. ADDRESS <i>1332 Prof. Bldg</i>	22c. DATE SIGNED <i>8/30/57</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>8-31-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oakland Cemetery</i>	23d. LOCATION (City, town, or county) <i>Harrisonville, Mo.</i>	(State)
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24. FUNERAL DIRECTOR <i>Atkinson Funeral Home, Harrisonville, Mo</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>8-31-57</i>	26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

G.R. Remhardt

20

DCT-3 1958

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 *John R. Didmo*

Licensed Embalmer No. *4531*

P. O. Address *Jennas City,*

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.