

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019675  
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5746

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
25 c. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>1519 Lovejoy Lane</b>	
Length of stay in lb <b>259</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Fields</b> Last <b>Fields</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1892</b>
9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b>9</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>	11. BIRTHPLACE (City and state or country) <b>Lexington, Miss.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Willis Fields</b>	
13b. MOTHER'S MAIDEN NAME <b>Minerva</b>		14. NAME OF HUSBAND OR WIFE <b>Clatie Fields</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>498-10-8553</b>	17. INFORMANT <b>Clatie Fields</b> Address <b>1519 Lovejoy Lane</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive vascular disease</b> DUE TO (c) <b>331X</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2	
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.)		
20c. TIME OF INJURY Hour <b>8:10a</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>1515 Lafayette</b>		COUNTY STATE
21. I attended the deceased from <b>5-28-58</b> to <b>5-31-58</b> and last saw <input checked="" type="checkbox"/> him alive on <b>5-31-58</b> Death occurred at <b>8:10a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Willis M. Linder M.D.</b> (Degree or title)		22b. ADDRESS <b>1515 Lafayette</b>	22c. DATE SIGNED <b>5-31-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6/5/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Missouri</b>
24. FUNERAL DIRECTOR <b>Charles J. Gates</b> ADDRESS <b>4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 3 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Park Smith, M.D.</b> <i>m.p.B.</i>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Gunston Swan* .....

Licensed Embalmer No. **4580** .....

P. O. Address **4107 Finney Ave** .....

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.