

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 20 1959

59-037343

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. — Registrar's No. 394

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 16Y;9M;17das.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No.4		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Unknown
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ALICE Middle FAIRFIELD Last FAIRFIELD			4. DATE OF DEATH Month October Day 1 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months 8 Days 7	IF UNDER 24 HR Hours — Min. —
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Stoddard Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME J. S. Fairfield	13b. MOTHER'S MAIDEN NAME Sarah Jane McLain	14. NAME OF HUSBAND OR WIFE None
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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.	17. INFORMANT 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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	instantaneous.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	Arteriosclerotic heart disease
	DUE TO (c)	unknown.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychosis with mental deficiency.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour — a.m. — p.m. 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 Farmington, Missouri	COUNTY —	STATE —
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21. I attended the deceased from Oct. 1, 1959 to Oct. 1, 1959 and last saw him/her alive on Oct. 1, 1959 Death occurred at 5:40 P. M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John A. Brennan, M.D.</i>	22b. ADDRESS State Hospital No.4 Farmington, Missouri	22c. DATE SIGNED 10-15-59
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23a. BURIAL, CREMATION, or REMOVAL (Specify) Removal	23b. DATE Oct. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY Washington Univ. Anat. Dept.	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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24. FUNERAL DIRECTOR Via Miller Funeral Home	ADDRESS Farmington, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 15, 1959	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul Dufal

Licensed Embalmer No. 4120
P. O. Address Farmington

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.