

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-007764**

FILED VS MAR 1 1960

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 52

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Charles</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u> c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>106 Washington St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>George P. Fields</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>February 23 1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-10-84</u>	<b>9. AGE (last birthday)</b> <u>75</u>	<b>IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>12</u> Hours _____ Min. _____ <b>IF UNDER 24 HR</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Masonic Lodge</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Charles County, Mo. USA</u>			
<b>13a. FATHER'S NAME</b> <u>Seth Fields</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Caroline Pratt</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Hilda Westerfeld</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>493-05-5395</u>		<b>17. INFORMANT</b> Address <u>Dr. Roy Westerfeld, St. Charles,</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Transverse Colon</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____ 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 INTERVAL BETWEEN ONSET AND DEATH <u>6-2 mo.</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>2-10-60</u> to <u>2/23/60</u> and last saw him alive on <u>2/23/60</u> Death occurred at <u>11:05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Paul W. Rothen MD</u>			<b>22b. ADDRESS</b> <u>St. Charles, Mo</u>		<b>22c. DATE SIGNED</b> <u>2/24/60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>2-25-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Grove Cemetery</u>			
<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Charles, Mo.</u>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u>					
<b>25. DATE RECD. BY LOCAL REG.</b> <u>2/25/60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Maree Wilson</u>					

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed David C. Bone

Licensed Embalmer No. 5060

P. O. Address St. Charles

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.