

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

**-60-033589**

**FILED VS SEP 13 1960 360**

Registration District No. \_\_\_\_\_ Primary Registration District No. **6225** Registrar's No. **188**

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Vernon</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Webster</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington Township</b>		Length of stay in 1b <b>1yr 8mos 28day</b>		c. CITY OR TOWN <b>Rogersville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital No. 3</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>\$ . R. R. #3</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Dela</b> Middle <b>F.</b> Last <b>Fielder</b>				<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>6,</b> Year <b>1960</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>10-7-1892</b>		<b>9. AGE (last birthday)</b> <b>67</b>		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Springfield, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>					
<b>13a. FATHER'S NAME</b> <b>William T. Fielder</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Minnie Mack</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Freda M. Fielder</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W. W. I</b>				<b>16. SOCIAL SECURITY NO.</b> <b>?</b>		<b>17. INFORMANT</b> Address <b>Records, State Hosp. No. 3, Nevada, Mo</b>							
<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) <b>Cerebral vascular accident</b>										INTERVAL BETWEEN ONSET AND DEATH <b>one day</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b>										<b>years</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					
<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>		COUNTY _____		STATE _____				
<b>21. I attended the deceased from</b> <b>12-9-58</b> <b>to</b> <b>9-6-60</b> <b>and last saw</b> <b>him</b> <b>alive on</b> <b>9-6-60</b> Death occurred at <b>12:10</b> <b>p</b> <b>m</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>Paul L Barone M.D.</b>						<b>22b. ADDRESS</b> <b>State Hosp. #3, Nevada, Mo</b>				<b>22c. DATE SIGNED</b> <b>9-6-60</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>9-6-1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>National Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Springfield, Mo.</b>		(State) _____					
<b>24. FUNERAL DIRECTOR</b> <b>Jewell E. Windle Funeral Home</b> <b>Springfield Missouri</b>				ADDRESS _____		<b>25. DATE RECD. BY LOCAL REG.</b> <b>9-9-1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Anna J. Jerry</b>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 15 1960

**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

*Percy F. Milster*

Licensed Embalmer No.

4805

P. O. Address

Newark, N.J.

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.