IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ILED VS NOV 9 1960

NDED

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 98

-60-038896
STATE FILE NUMBER

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: LAWRENCE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 5655 Mt. Vernon — Length of stay in 1b: 6 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: MISSOURI STATE SANATORIUM — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: STODDARD
c. CITY OR TOWN: ESSEX — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MARION Middle: LEE Last: FIELDER
4. DATE OF DEATH: Month: November Day: 4 Year: 1960
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 3-7-00
9. AGE (last birthday): 60 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): BOANIAMY, ILLINOIS
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: JON FIELDER
13b. MOTHER'S MAIDEN NAME: FANNY FIELDER
14. NAME OF HUSBAND OR WIFE: BERTHA FIELDER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): EARLY 20'S NAVY
16. SOCIAL SECURITY NO.: 498-14-4058
17. INFORMANT: SELF. Address: Hospital record

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 6-7 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) HYPERTENSIVE ENCEPHALOPATHY — 6-7 days
DUE TO (c) MALIGNANT HYPERTENSION — 5 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PULMONARY TUBERCULOSIS ACTIVITY UNDETERMINED

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-29-60, to 11-4-60 and last saw her/him alive on 11-4-60.
Death occurred at 5:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C E Hellweg (Degree or title) M.D.
22b. ADDRESS: Mo. State San. Mt. Vernon
22c. DATE SIGNED: Nov 4 1960

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal.
23b. DATE: 11-7-60
23c. NAME OF CEMETERY OR CREMATORY: Dudley Cem.
23d. LOCATION (City, town, or county) (State): Dudley Mo.

24. FUNERAL DIRECTOR: Rainey F Home Dexter Mo — ADDRESS
25. DATE RECD. BY LOCAL REG.: 11-5-60
26. REGISTRAR'S SIGNATURE: H L Forsett

(Licensed Embalmer's Statement on Reverse Side)

NOV 29 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by Me, Student Embalmer No.

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H O Lassett

Licensed Embalmer No. 220

P. O. Address Mt Vern

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.