

No. 2
4-5-43
5-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27690

FILED AUG 23 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6994

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME GEORGE E. FIFIELD, Jr.,

3. (b) If veteran, name war None. 3. (c) Social Security No. 492-10-4874

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Married.

6. (b) Name of husband or wife Gertrude Fifield, 6. (c) Age of husband or wife if alive 61. years

7. Birth date of deceased October 20, 1885. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62. 9. 18. hr. min.

9. Birthplace Chicago, Illinois. (City, town, or county) (State or foreign country)

10. Usual occupation V. P. Rothschild Hat Co.,

11. Industry or business _____

12. Name George E. Fifield.

13. Birthplace Indiana. (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Gertrude Fifield,

(b) Address 6179 McPherson Ave.,

17. (a) Interment. (b) Date thereof 8/11/48. (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery.

18. (a) Signature of funeral director C.R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.,

19. (a) AUG 9 - 1948 (b) J. F. Bredich (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 600
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 6179 Mc Pherson Blvd. 9
(If rural, give location)
(e) Citizen of foreign country? no 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 8 year 1948 hour 6:40 minute P. M.

21. I hereby certify that I attended the deceased from Aug 8 to Aug 8 and that death occurred on the date and hour stated above.

Immediate cause of death Uræmia Duration 2 wks.

Due to Lympho-sarcoma of 4 mos

Due to Septicæmia ad. mod

Other conditions 52

(Include pregnancy within 3 months of death)

Major findings: Lymphosarcoma

Of operations Kidney

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

Means of injury 0

23. Signature Arthur E. Stoddard (M. D. or other)

Address 579 N. Grand Date signed 8/11/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Alum tott 1929.
92-6525
1/30 - 5

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Arnold W. Schoene
Licensed Embalmer No. 3864
P. O. Address St. Louis, Mo.

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 this body is not embalmed, fact should be so stated above.