WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30671

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. .....

or

Village ..... Primary Registration District No. 1003 Registered No. 8571

or

City St. Louis (No. 2757 La Salle St.; 15 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Augustine Fields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col'd

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Wid

6 DATE OF BIRTH: June (Month) 12 (Day) 1855 (Year)

7 AGE: 57 yrs. 1 mos. 29 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Fields
(Address) 2757 La Salle

15 Filed Sep 22 1918, 191 Max C. Starkloff Registrar

2 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 10 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sep 7, 1918, to Sep 10, 1918, that I last saw h. alive on Sep 9, 1918, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:
Acute Gastritis
12 hrs
11 hrs
10 hrs
(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Hepatitis
(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. Fabian Moore M. D.
Sep 11, 1918 (Address) 1326 Franklin

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Greenwood DATE OF BURIAL: ..... 191....

20 UNDERTAKER: Lorenz [illegible] ADDRESS: [illegible]

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from .....191....., to .....191.....

that I last saw h.....alive on .....191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

....., 191.....

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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