

SEP 29 1934

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

Do not use this space.

29845

1. PLACE OF DEATH

County Knox Registration District No. 439
Township Greensburg Primary Registration District No. 5596
City (No. St. Ward)

File No.
Registered No.

2. FULL NAME

(a) Residence, No. St. Ward
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 2 - 1891

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
63 7 11

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farming

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knox Co Mo

13. NAME William Fields

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

15. MAIDEN NAME Sarah White

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Warner Fields Greensburg Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Greensburg DATE Aug 5, 1934

19. UNDERTAKER (ADDRESS) Card & Oakes Memphis Mo

20. FILED Aug 20 1934 B. E. M. Whitson Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 2, 1934, to Aug 13, 1934

22. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1934, to Aug 13, 1934

I last saw him alive on Aug 9, 1934. Death is said to have occurred on the date stated above, at 7:00 p.m.

The principal cause of death and related causes of importance were as follows:

Heart attack, apoplexy
mitral stenosis

Other contributory causes of importance:

Influenza year ago a while left him in weakened condition

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) E. M. Whitson D. O., M. D.
(Address) Baring, Mo.

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH *Know*
 County *Know* Registration District No. *439*
 Township *Greensburg* Primary Registration District No. *5596*
 City (No. St. Ward)

2. FULL NAME *William Riley Fields*
 (a) Residence, No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE; MARRIED, WIDOWED, OR DIVORCED (*write the word*) *Mar.*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan-2-1891*

7. AGE YEARS *63* MONTHS *7* DAYS *11* If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED *Aug 20 1934* *D. C. M. Whitmore* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug. 11 1934*

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____. I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of _____
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury _____, 19____.
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____

(Signed) _____, M. D.
 (Address) _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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