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MAY 15 1940
Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution Hodiamont Hospital
(If outside city or town limits, write "RURAL" and name of township)
(If 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 Marion Field ^{WIFE} 430

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mr. Marion Field 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 16 1881
(Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Watertown New York
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Abraham Fairwell

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

14. Maiden name Unknown

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

16. (a) Informant: Mrs Irene G. Backlund

(b) Address 1185 Hodiamont Ave

17. (a) Burial (b) Date thereof April 19 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Chas. H. Stuart

(b) Address 1225 N. Union Blvd.

19. (a) APR 18 1940 (b) J. F. Backlund
(Date of death) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 5
(If outside city or town limits, write "RURAL")
(d) Street No. 1185 Hodiamont
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16
year 1940 hour 10:25 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic Edema

Due to Chronic Fibrous Myocarditis

Due to with Aortic Valve

Other conditions Stenosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 92a

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature Joseph M. Quinn (M. D. or other)

Address Quincy Corner Date signed _____

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

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 Guy W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.