No. 2
1-10-39
17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39716

Registration District No. 784 Primary Registration District No. 106 Registrar's No. 2205

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Kirkwood (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: U. S. Marine Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 days (Specify whether years, months or days)

In this community 48 days 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Washington (If outside city or town limits, write "RURAL")

(d) Street No. 23 West Second Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? X years.

3. (a) PRINT FULL NAME CHARLES H. FIELD

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alma

6. (c) Age of husband or wife if alive years

7. Birth date of deceased February (Month) 5 (Day) 1893 (Year)

8. AGE: Years 47 Months 9 Days 17 If less than one day hr. min.

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

10. Usual occupation Overseer

11. Industry or business U. S. Engineer Corps

FATHER
12. Name James Field
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mattie Walker
15. Birthplace (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs. Alma Field

(b) Address Washington, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 22, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Missouri

18. (a) Signature of funeral director Hiburg & Vitt Inc

(b) Address Washington, Mo. By A. C. Nielsen

19. (a) NOV 22 1940 (Date received local registrar) (b) T. K. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22 year 1940 hour 10 minute 40 a.M.

21. I hereby certify that I attended the deceased from October 3, 1940 to November 22, 1940; that I last saw him alive on November 22, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death To be given in supplemental report following microscopic examination of tissues

Due to

Due to

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

Major findings: Of operations same

Of autopsy same

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. Ollougherty (M. D. or other)

Address U.S. Marine Hospital Kirkwood Date signed 11-22-40

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 2387

P. O. Address Washington, N

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, above space should be left blank.

No. 2
-10-39
17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 784 Primary Registration District No. 106 Registrar's No. 2205

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Kirkwood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Marine Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: ~~Ste. Louis~~

(c) City or town: Washington, Missouri
(If outside city or town limits, write "RURAL")

(d) Street No.: 25 West 2nd St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME: Charles H. Field

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife: Alma 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Feb. (Month) 5th (Day) 1893 (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

MOTHER 14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) DEC 24 1940 (Date received local registrar) (b) T R Meyer M D (Registrar's signature)

This Certificate is filed as a supplement
The certificate filed on November 22nd, 1940

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22nd year 1940 hour _____ minute _____ M.

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

Immediate cause of death	Duration
Hepatitis, acute, toxic	
etiology undetermined	Unknown
Bronchopneumonia, bilateral	Unknown
Due to	
Due to	
Other conditions: Chronic pancreatic cirrhosis	
(Include pregnancy within 3 months of death) Chronic, Cholecystitis	

Major findings:
Of operations _____
Of autopsy _____

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature: J. T. Deloughery (M. D. or other)
Address: Marine Hospital Date signed: 12-23-40

(Licensed Embalmer's Statement on Reverse Side)

1940
S-39716

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.