

Registration District No. 492Primary Registration District No. 562-2-40

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Lincoln
 (b) City or town Winfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 (Specify whether

In this community
years, months or days3. (a) PRINT FULL NAME George Winston Fielder3. (b) If veteran, name war No 3. (c) Social Security No. 497-09-17944. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Anna Senoria Fielder 6. (c) Age of husband or wife if alive 65 years7. Birth date of deceased June 15 1913
(Month) (Day) (Year)8. AGE: Years 67 Months 7 Days 18 If less than one day hr. min.9. Birthplace Lincoln County Missouri
(City, town, or county) (State or foreign country)10. Usual occupation mail carrier from P.O.11. Industry or business R.R. Station12. Name Jacob Isaac Fielder13. Birthplace Pike County Mo.
(City, town, or county) (State or foreign country)14. Maiden name Mrs. Joe Hicks
15. Birthplace Missouri
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Anna Senoria Fielder(b) Address Winfield, Mo.17. (a) Burial (b) Date thereof 2-5-41
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oakum Cemetery18. (a) Signature of funeral director Edna Hicks(b) Address Winfield, Mo.19. (a) 2/4/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 3
year 1941 hour 1 minute 40 P. M.21. I hereby certify that I attended the deceased from 1-30
_____, 1941, to 2-3, 1941,
that I last saw him alive on 2-3, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death

Paralysis (Hemiplegia)
Due to Arterial SclerosisDue to _____
Other conditions (include pregnancy within 3 months of death) LMajor findings:
Of operations LOf autopsy L

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?
Y

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

23. Signature [Signature] (M. D. or other) D
Address Edna Hicks Date signed 2/4/41

5210

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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..... *D'Galan Ricks*
Licensed Embalmer No. *4012*
P. O. Address..... *Winfield, Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8231

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 492

Primary Registration District No. 4299

Registrar's No. _____

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Geo. Kingston Fieldes

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month Feb day 3
year 1941 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 Paralysis (Cerebral) Paralysis Hem
Due to arterial sclerosis

Due to _____
Other conditions (Include pregnancy within 3 months of death) § 20

Major findings: Of operations _____
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) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address [Address] Date signed 4/10/41

SUPPLEMENTAL ONLY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

