

S. No. 2
DOM-2-43
5-17-39
I X35697

25895

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 7 1944

Registration District No. 341

Primary Registration District No. 6152A

Registrar's No. 34

1. PLACE OF DEATH: **Stoddard**

(a) County.....

(b) City or town **Rural, Liberty Twp.**
(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) 1

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Stoddard 10-3**

(c) City or town **Liberty Twp.** 0
(If outside city or town limits, write "RURAL") 0

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Joseph H. Birchfield**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **1**
year **1944** hour **8** minute **0 a.** M.

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

6. (b) Name of husband or wife **Mollie Birchfield** 6. (c) Age of husband or wife if alive **64** years

7. Birth date of deceased **Jan. 19, 1873**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 2nd 1944 to July 1st 1944
that I last saw him alive on June 15th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration 6 days

8. AGE: Years Months Days If less than one day
71 5 12 hr. min.

Due to Chronic Myocarditis & Arteriosclerosis

Due to.....

9. Birthplace **Stoddard Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

Other conditions..... (include pregnancy within 3 months of death)

Major findings:
Of operations.....

11. Industry or business.....

MOTHER FATHER { 12. Name **Jerry Birchfield**

13. Birthplace **No Record** 9
(City, town, or county) (State or foreign country)

14. Maiden name **Paralee Howell**

15. Birthplace **No Record** 9
(City, town, or county) (State or foreign country)

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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)

16. (a) Informant **Arthur Birchfield**

(b) Address **Dexter, Mo.**

17. (a) **Burial** (b) Date thereof **7-2-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **C. Dowdy Cem.**

18. (a) Signature of funeral director **Blankenship-Strickland**

(b) Address **Dexter, Mo.**

19. (a) **6-28-44** (b) **Nora Smith**
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature **J. S. [unclear]** (M. D. or other)
Address **Dexter, Mo.** Date signed **7/1/44**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

300

RECEIVED

District Health Office No. 2,

District File Number 8-4-1057

Date Filed 8-4-44

AUG 7 1944

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. 3479

P. O. Address Hyattsville, Md.

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, fact should be so stated above.