

No. 2
1-2-43
5-17-39
X33697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2982
State File No. _____
Registrar's No. _____

Registration District No. 254

Primary Registration District No. 4386

1. PLACE OF DEATH:
(a) County Oregon
(b) City or town Thayer
(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 10 years _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Oregon 75
(c) City or town Thayer 1
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Isabel Louise Field
3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-18-7735

MEDICAL CERTIFICATION
20. **DATE OF DEATH:** Month Dec. day 18
year 1944 hour about 7 minutes 30 M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed
6. (b) Name of husband or wife Frank Field 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 19 1869
(Month) (Day) (Year)

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.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>11</u>	<u>29</u>	_____ hr. _____ min.

Immediate cause of death
Congestive Heart Failure
Due to chronic Coronary Arteriosclerosis
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 940
Of autopsy _____

10. Usual occupation _____
11. Industry or business _____
12. Name Gilman Harding
13. Birthplace Mass.
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Mass.
(City, town, or county) (State or foreign country)

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) (c) Means of injury _____

16. (a) Informant Arthur G. Harding
(b) Address Kansas City, Kansas
17. (a) Burial (b) Date thereof 12/20/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leavenworth, Kansas
18. (a) Signature of funeral director Lee Saw
(b) Address Thayer, Mo.
19. (a) 1-15-45 (b) Jae W. Williams
(Date received local registrar) (Registrar's signature)

23. Signature Rev. Carr (M. D. or other) _____
Address Thayer Date signed 1/14/45

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

0-1-5

1062

RECEIVED

District Health Officer No. 5

District File Number 245-79

Date Filed 2-12-45

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, fact should be so stated above.

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 (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 _____
years, months or days

3. (a) PRINT FULL NAME

Isabel F. Field

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 19 1906
(Month) (Day) (Year)

8. AGE: Years 74 Months 11 Days _____
If less than one day, _____ min.

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

10. Usual occupation Key Operator

11. Industry or business Clark Central Tel. Co.

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Feb W. Williams
(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) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day _____
 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

2982