

No. 1
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-5-17-39
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DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

State File No. 19240

Registration District No. 354

Primary Registration District No. 1199

Registrar's No.

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Impo
(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 12 years
In this community 12 years (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Bertha Rehberg Fielding
3. (b) If veteran, name war. No
3. (c) Social Security No.

4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife John B. Fielding
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased December 31, 1872 (Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 11 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant John B. Fielding

(b) Address Mt. Grove, Mo.

17. (a) Burial (b) Date thereof. May 14 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Hillcrest

18. (a) Signature of funeral director Russell Barber

(b) Address Mt. Grove, Mo.

19. (a) 16-20-46 (b) Hayville Cunningham (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12 year 1946 hour 6:15 minute 9 P. M.
21. I hereby certify that I attended the deceased from Jun 1, 1946 to May 12, 1946 that I last saw her alive on 5/10, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac insufficiency

Due to

Due to

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

Major findings: Of operations 950 Of autopsy

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?

While at work? (Specify type of place) (e) Means of injury 0

23. Signature R.A. Ryan (M. D. or other)

Address Mt. Grove Date signed 5/13/46

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

33
24-7-42
1942

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.

Registration District No. 354

Primary Registration District No. 6199

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Imperial
(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 _____
years, months or days

3. (a) PRINT FULL NAME Betha R. Fielding

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 m

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

7. Birth date of deceased see 3
(Month) (Day) (Year)

8. AGE: Years 73 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 _____

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 of burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) June 20 (b) Gayrell Cunningham
(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 _____ Year 1946 hour _____ minute _____ M.

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

Due to _____

Due to _____

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

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)
(c) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

19240