

FILED AUG 15 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24347

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 159

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Marceline</u> <u>0581</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp. 6da.</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>200 W. Curtis</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Fields</u> First Middle Last			4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>56</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/56</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boilmaker</u>	9b. KIND OF BUSINESS OR INDUSTRY <u>Santa Fe</u>	9c. AGE (In years last birthday) <u>73</u>	9d. IF UNDER 1 YEAR IF UNDER 24 HRS. Month <u>10</u> Days <u>6</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boilmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Santa Fe</u>	10c. BIRTHPLACE (City and state or country) <u>Chariton Co.</u>
11. BIRTHPLACE (City and state or country) <u>Chariton Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fields</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>499 366405</u>	
17. INFORMANT <u>Aufrey Fields</u>		Address <u>Marceline, Mo...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO (b) <u>Myocardial Damage (Myocarditis)</u> DUE TO (c) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4) Hemorrhagic Bladder &amp; Bladder Hypertrophy &amp; Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>	
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>March 1955</u> to <u>July 13, 1956</u> and last saw <u>him</u> alive on <u>July 13, 1956</u> . Death occurred at <u>3:55</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George J. Laughlin</u>		22b. ADDRESS <u>Marceline Missouri</u>	
22c. DATE SIGNED <u>7-14-56</u>			
23a. BURIAL, CREMATION, REMAINS (Specify) <u>B</u>		23b. DATE <u>7-16-56</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Not Above</u>		23d. LOCATION (City, town, or county) (State) <u>Marceline Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>John M. Laughlin, Marceline</u>		25. DATE RECD. BY LOCAL REG. <u>7-16-56</u>	
26. REGISTRAR'S SIGNATURE <u>M. J. Pignone</u>			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

Health, Welfare Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

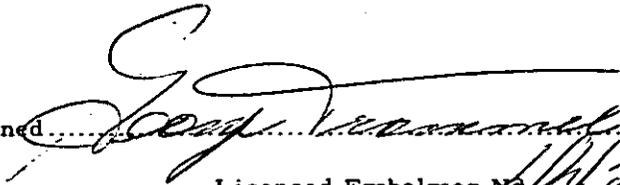
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.