

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24530**

FILED JUL 30 1956

BIRTH NO. _____ REG. DIST. NO. **254** PRIMARY REG. DIST. NO. **4386** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Arkansas b. COUNTY Craighead	
b. CITY (If outside corporate limits, write RURAL and give township) Thayer	c. LENGTH OF STAY (in this place) 25 days	c. CITY OR TOWN Bay	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Richard's Rest Home		e. STREET ADDRESS (If rural, give location) 802^o S	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Dora	b. (Middle) Lee	c. (Last) Fielder	(Month) July	(Day) 25	(Year) 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH April 22, 1884		9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Huntsville, Alabama		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME J. N. Fielder	13b. MOTHER'S MAIDEN NAME DeArmon	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Jess Haynes, Thayer, Missouri	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying; such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Quinzel Qateresebman		INTERVAL BETWEEN ONSET AND DEATH Dec 1955
	ANTECEDENT CAUSES DUE TO (b) Eye condition DUE TO (c) Fracture Left leg		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 075
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **March, 1956**, to **July 25, 1956**, that I last saw the deceased alive on **7-25, 1956**, and that death occurred at **12:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE D W Cooper MD	(Degree or title) MD	23b. ADDRESS Thayer Mo	23c. DATE SIGNED 7-25-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 27, 1956	24c. NAME OF CEMETERY OR CREMATORY Bowman Cemetery	24d. LOCATION (City, town, or county) (State) Craighead County, Arkansas
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DATE REC'D BY LOCAL REG. 7-25-1956	REGISTRAR'S SIGNATURE Arthur Wolf	25. FUNERAL DIRECTOR'S SIGNATURE Edward Curtis Meyer MD	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

4680

James ...
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 *James ...*, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James Carter*.....

Licensed Embalmer No. *4516*.....

P. O. Address *Hayes, Va.*.....

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.