

FILED FEB 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5347

BIRTH NO. _____		REG. DIST. NO. <u>170</u>		PRIMARY REG. DIST. NO. <u>3033</u>		Registrar's No. <u>26</u>	
1. PLACE OF DEATH a. COUNTY <u>Laclede</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lebanon</u>			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>Lebanon</u> <u>0532</u>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>619 BAand Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>619 Rland Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>BYRDIE</u>			b. (Middle) <u>MAE</u>		c. (Last) <u>FAIRFIELD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17, 1957</u>
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>		8. DATE OF BIRTH <u>Aug. 23, 1882</u>		9. AGE (In years last birthday) <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>York, Neb.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Jackson</u>			13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>James A. Fairfield</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Jack Fairfield, Lebanon, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Perniciou anemia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Hypertrophic arthritis</u> <u>Fracture left femur</u> <u>residual deformity</u>					INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) _____		2	
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? _____			
22. I hereby certify that I attended the deceased from <u>Oct. 1955</u> , to <u>2-17-1957</u> , that I last saw the deceased alive on <u>2-16-1957</u> , and that death occurred at <u>3:30A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>B B Hurst, M.D.</u>				23b. ADDRESS <u>Lebanon, Mo.</u>		23c. DATE SIGNED <u>2-18-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2-19-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>York Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>York, Neb.</u>		
DATE REC'D BY LOCAL REG. <u>2-19-1957</u>		REGISTRAR'S SIGNATURE <u>Hella L. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S R Palmer Lebanon, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

724

Received 2-25-57
Laclede County Health Unit
File No. 26
Date Filed 2-25-57

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 Stanley R Palmer
Licensed Embalmer No. 481
P. O. Address Lebanon,

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.