

Health,  
, & Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14961

STATE FILE NUMBER

FILED DEC 10 1957

Registration District No. **318** Primary Registration District No. **1003**

Registrar's No. **11399**

S. 300  
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Mexico</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist</u>		d. STREET ADDRESS (If outside, give location) <u>R. F. D. #3</u>	
Length of stay in lb <u>4 Weeks</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hardin</u> Middle <u>Field</u> Last <u>Field</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>26</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 6, 1887</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>02</u> Days <u>43</u>	IF UNDER 24 HRS. Hours <u>02</u> Min. <u>43</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Mexico, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>John H. Field</u>	
13b. MOTHER'S MAIDEN NAME <u>Eliza Ann French</u>		14. NAME OF HUSBAND OR WIFE <u>None</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>None</u>	
17. INFORMANT Address <u>Roy Field 806 N. Craig St. Mexico 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>uraemia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>uraemia</u> DUE TO (c) <u>Carcinoma of Bladder</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 mos.</u> <u>1 1/2 to 2 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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>181x</u>		20c. TIME OF INJURY Hour <u>11</u> Month <u>11</u> Day <u>29</u> Year <u>1957</u> a.m. <u>00</u> p.m. <u>00</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 <u>Mexico</u> COUNTY <u>Missouri</u> STATE <u>Mo</u>		21. I attended the deceased from <u>Oct 3 1957</u> to <u>Nov 26 1957</u> and last saw him alive on <u>Nov 26 1957</u> Death occurred at <u>7:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Carl Smith M.D.</u>		22b. ADDRESS <u>958 Arceneburg Edin Va</u>	
22c. DATE SIGNED <u>Nov 27 57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>11/29/57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>	
23d. LOCATION (City, town, or county) <u>Mexico, Missouri</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Arnold Funeral Home Mexico, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>NOV 27 57</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		m & B	

Dr. C. E. Burford  
Arcade Bldg  
10 to 12 Noon  
Ch. 1-7040

*Dr. C. E. Burford*

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 *Riley Taylor* .....

Licensed Embalmer No. *3239* .....

P. O. Address *Mexico Mo* .....

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.