MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7273

PLACE OF DEATH

County Mississippi

Township ~~St James~~ or Village East Prairie or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 567 File No. _____

Primary Registration District No. 4334 Registered No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Isaac Fisher

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: March (Month) _____ (Day) 1856 (Year)

AGE: 59 yrs. 11 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): By self

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS
NAME OF FATHER: [illegible]
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Marie Powers
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Fisher

(ADDRESS) East Prairie Mo.

Filed Feb-26 1916 D M Hodges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: February (Month) 25 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Feby 12th, 1916, to Feby 25th, 1916, that I last saw him alive on Feby 25th, 1916, and that death occurred, on the date stated above, at 8:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute septic cystitis

124

(Duration) ___ yrs. ___ mos. 13 ds.

Contributory (SECONDARY): Chronic prostatitis ~~Chronic interstitial nephritis~~

(Duration) ? yrs. ___ mos. ___ ds.

(Signed) Hobart R Hunter M. D.

Feby 26th 1916 (Address) East Prairie - Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Long Wood

DATE OF BURIAL: Feb 27 1916

UNDERTAKER: Ted Shelly

ADDRESS: East Prairie

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PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ...., 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

(Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Farmer (retired, 6 yrs.)* fact may be indicated thus: For persons who have no occupation whatever, write *None*.