

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

Do not use this space.

32074

1. PLACE OF DEATH

County Lafayette
Township Spencer
City _____ (No. _____)

Registration District No. 466
Primary Registration District No. 5622-B

File No. _____
Registered No. 93
St. _____ Ward _____

2. FULL NAME

A. B. Fisher

(a) Residence No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

about 83

YEARS MONTHS DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Inmate of

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

State

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Do not know

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Do not know

14.

INFORMANT J. L. Howard, Attendant
(Address) Higginsville Mo.

15.

FILED Oct 31 19 26 Basin P. Foster
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 31 19 26

17. I HEREBY CERTIFY, That I attended deceased from July 1 19 24 to Oct 31 19 26 that I last saw him alive on Oct 20 19 26, and that death occurred, on the date stated above, at about 6 o'clock P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pharyngitis
131 129A
80A Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical

(Signed) M. H. Foster, M. D.

, 19 (Address) Higginsville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **DATE OF BURIAL**

Home Cemetery Nov. 1 19 26

20. UNDERTAKER **ADDRESS**

W. H. Stader Higginsville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

26 1927

RECORD WITH EMPLOYING INSTITUTION IS A PERMANENT RECORD

