

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

Do not use this space.

1. PLACE OF DEATH

County Linn Registration District No. 503
Township Porter Creek Primary Registration District No. 306
City Maechville Mo. (No. St. Ward)

File No. 37463
Registered No.

2. FULL NAME Charlotte Fisher

(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-12-1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 9 13

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Jacob Rapp

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Esther Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Miss. June Myers
(Address) Maechville

15. FILED 12-13-27 E J Weir
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13th 9-46-1927

17. I HEREBY CERTIFY, That I attended deceased from 12-12-1927 to 12-12-1927, that I last saw her alive on 12-12-1927, and the death occurred, on the date stated above, at 9-45-a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Thrombosis
523

CONTRIBUTORY (SECONDARY) Coronary vascular
Renal Disease

18. WHERE WAS DISEASE CONTACTED IF NOT AT PLACE OF DEATH 129 W

19. DID AN OPERATION PRECEDE DEATH DATE OF WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) E J Weir M. D.
E J Weir
12-13-27 (Address)

*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 Cluna DATE OF BURIAL 12-13-27

20. UNDERTAKER Smiley Bros ADDRESS Maechville

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ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Linn Registration District No. 503 File No. _____
 Township _____ Primary Registration District No. 4306 Registered No. _____
 City Meadville (No. _____) St. _____ Ward _____

2. FULL NAME Charlotta Fisher

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 26 - 1847

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>80</u>		<u>9</u>	<u>17</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. Feb 15 1927 E. W. Warr
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 13 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, 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.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
 WAS THERE AN AUTOPSY: _____
 WHAT TEST CONFIRMED DIAGNOSIS: _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*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 _____
20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

RECEIVE A FEE 1 CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5945-5