

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

Do not use this space.

1. PLACE OF DEATH

County *Morgan*  
Township *Hawford*  
City *Stewart* (No. ....)

Registration District No. *953*  
Primary Registration District No. *5793 B*

File No. *24535*  
Registered No. *7* (St. .... Ward)

2. FULL NAME

*Leester Lee Fisher*

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

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 5 1927*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *1 1 5*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *none* (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) *Morgan Co Mo*

10. NAME OF FATHER *Joseph Fisher*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Morgan Co Mo*

12. MAIDEN NAME OF MOTHER *Rachel James*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Morgan Co Mo*

14. INFORMANT (Address) *Joe Fisher Stewart*

15. FILED *July 14 1928* *Julius H. Cooper* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 10 1928*

17. I HEREBY CERTIFY, That I attended deceased from *July 1 1928* to *July 10 1928* that I last saw *him* alive on *July 10 1928* and that death occurred, on the date stated above, at *7:15 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS: *Bronchial pneumonia*

CONTRIBUTORY (SECONDARY) *Whooping cough* (duration) yrs. mos. *10* da.

18. WHEN WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

19. WAS THERE AN AUTOPSY? *no* WHAT TEST CONFIRMED DIAGNOSIS? *clinical*

(Signed) *A. J. Seaman* M. D. (Address) *DeWalle, 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, CEMETERY, OR REMAINS DATE OF BURIAL *July 11 1928*

20. UNDERTAKER *Wm F. Kirtwell* ADDRESS *DeWalle, Mo.*

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.

