

1928

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

Do not use this space.

1. PLACE OF DEATH

County Saline
Township
City Marshall (No.) St. (Ward)

Registration District No. 796
Primary Registration District No. 3038

File No. 29368
Registered No. 132

2. FULL NAME

Willoughby Clark 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 MEDICAL CERTIFICATE OF DEATH

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 65

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Supt. of County Schools
(b) General nature of industry, business, or establishment in which employed (or employer) Schools
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER

unknown

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

12. MAIDEN NAME OF MOTHER Julia Hull

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

14. INFORMANT Mrs W. C. Fisher
(Address) Marshall Mo

15. FILED 8-18-28 Mrs. John H. McQuire
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1928

17. I HEREBY CERTIFY That I attended deceased from July 12, 1928, to Aug 13, 1928, that I last saw him alive on Aug 13, 1928, and that death occurred on the date stated above, at 9:45 P M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

99%
130 Embolism partial
1513 Circulation
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Amputation left leg
(duration) yrs. mos. ds. 24

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

2. DID AN OPERATION PRECEDE DEATH? Yes DATE OF Aug 11-1928

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

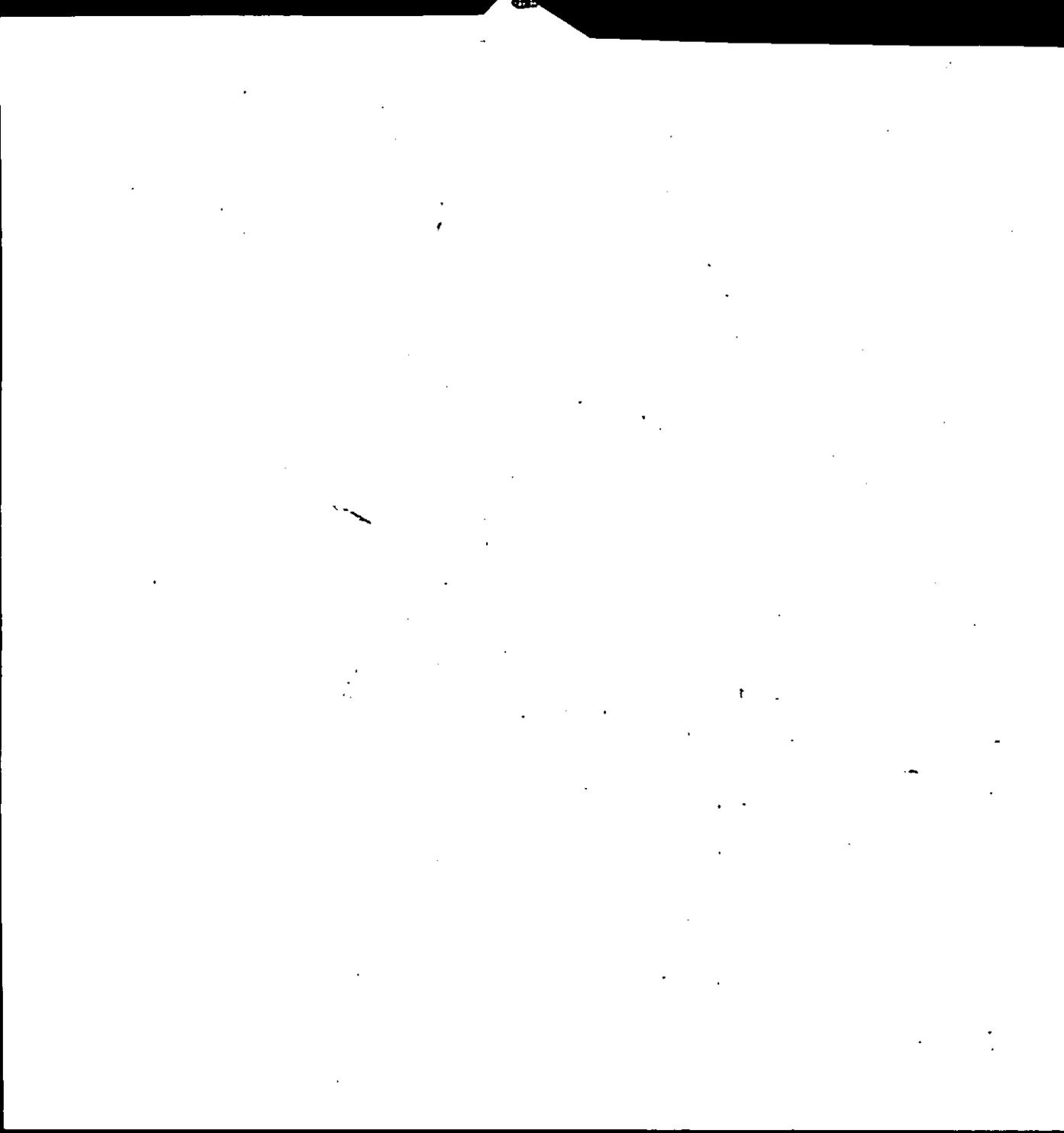
(Signed) R. W. Campbell, M. D.

Aug 15, 1928 (Address) Marshall 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 Ridge Park Cem DATE OF BURIAL Aug 15 1928

20. UNDER-TAKER R. W. Campbell ADDRESS Marshall



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

ALL INFORMATION CALLED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Saline
 Township Marshall
 City Marshall (No.)

Registration District No. 796
 Primary Registration District No. 3038

File No.
 Registered No. 132
 St. Ward)

2. FULL NAME

Willoughby Clark 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

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

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.

FILED 8-18-28 Mrs. John H. McQuinn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1928

17. I HEREBY CERTIFY, That I attended deceased from 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:

Embolic partial
circulation
of the parenchyma
of the left leg
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Impairment left leg
 (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

S-29368