

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

Do not use this space.

33624

4164

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Law Primary Registration District No. _____
 City Kansas City (No. Kansas City Genl Hosp) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

(a) Residence. No. 575 Grand St., 1 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) Dec. 25 - 1895

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
76 / 9 / 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blazer - 930
 (b) General nature of industry, business, or establishment in which employed (or employer) 95B
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER David Fisher

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

12. MAIDEN NAME OF MOTHER Mary Hood

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

14.

INFORMANT Reuben Clark
 (Address) 7-C General Hosp.

15.

FILED 10/13, 1928 MM Crowl
Asst. REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-9 1928

17. I HEREBY CERTIFY, That I attended deceased from 10-2, 1928, to 10-9, 1928.
 that I last saw him alive on 10-9, 1928, and that death occurred, on the date stated above, at 10:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart disease hypertensive with nephritis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Gen Fund & Autopsy
 (Signed) E. Williams, M. D.

10-10, 1928 (Address) Subst 7-C Genl Hosp.

*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

Maple Hill

10-15 1928

20. UNDERTAKER

ADDRESS

O. V. Mast

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.

AINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

**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.....
Township.....
City *St. Louis* (No.....)

Registration District No. *399*
Primary Registration District No. *1082*

File No.....
Registered No. *74-164* St. Ward)

2. FULL NAME

(a) Residence. No..... St., Ward.
(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 *S*
(Write the word)

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 *10/3/20* *M.M. Corvire* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10-9-1928*

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw h..... alive 19..... and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:
Heart Disease Hypertensive with nephritis Chronic myocarditis and Chronic Nephritis

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED 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 19

20. UNDERTAKER ADDRESS *K. G. Moore*

SUPPLEMENTARY

WRITE FULLY, WITH UNFADING INK... PERMANENT RECORD
N. B.— Information should be carefully supplied. AGE is to be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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