

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

Do not use this space.

1013

1. PLACE OF DEATH

County Franklin
Township Prairie
City (No.)

Registration District No. 301
Primary Registration District No. 37-18

File No.
Registered No.
St. Ward

2. FULL NAME Grover A. Fisher

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

Length of residence in city or town where death occurred 40 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 31st 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40 — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Disable Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Clair Mo
(STATE OR COUNTRY) Franklin County

10. NAME OF FATHER Garry Fisher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Moselle Mo
(STATE OR COUNTRY) Franklin County

12. MAIDEN NAME OF MOTHER Sarah Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT Mrs Grover A. Fisher
(Address) St. Clair, Mo.

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

17. I HEREBY CERTIFY That I attended deceased from 1/20, 1926 to Jan 31, 1929 that I last saw him alive on Jan 26, 1929 and that death occurred, on the date stated above, at 8 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency
P.P.A.
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ✓

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) W. E. Michael, M. D.
71-, 1929 (Address) St. Clair

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. John Evangelical Church
Convent Mt Hope Mo DATE OF BURIAL Feb 3rd 1929

20. UNDERTAKER Wright Horn ADDRESS Union, Mo.

OF DEATH in plain terms, so that it may be properly classified. Enter full name of informant. **MAR 21 1929**

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

**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 Franklin Registration District No. 301 File No. _____
 Township Boone Primary Registration District No. 5418 Registered No. _____
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Yvonne A 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 40 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) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Ellen Fisher
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 31st 1889
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40

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

9. BIRTHPLACE (CITY OR TOWN) St. Clair Mo.
 (STATE OR COUNTRY) Franklin

10. NAME OF FATHER Jerry Fisher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Clair Mo.
 (STATE OR COUNTRY) Franklin Co.

12. MAIDEN NAME OF MOTHER Elizabeth Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
 (STATE OR COUNTRY)

14. INFORMANT Yvonne A Fisher
 (Address) St. Clair Mo.

15. FILED 3/25 1929 S. L. DeWitt M.D.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 19 29
 17. I HEREBY CERTIFY That I attended deceased from 9/20 to Jan 31 19 29
 that I last saw him alive on Jan 31 19 29 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Heart Insufficiency

CONTRIBUTORY (SECONDARY)
 (Duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. G. Fitchell, M. D.
 , 19 (Address) St. Clair

*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 St. John's Evang. Church DATE OF BURIAL Feb 3 19 29
Cent Hope Mo.

20. UNDERTAKER Wm N Horn ADDRESS Union Mo

WRITE PLAIN! WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE, MEANS, and NATURE OF INJURY in plain terms, so that it may be properly classified. OCCUPATION is very important. DECEASED SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

PERMANENT

S-1013

Part 1013

1013