

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

Do not use this space.

10851  
1361

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Stau Primary Registration District No. 1 3/4  
 City Kansas City (No. 3619 Lexington) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. \_\_\_\_\_ Registered No. \_\_\_\_\_

2. FULL NAME Stella Elicone Elicene Fisher  
 (a) Residence. No. 3619 Lexington 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 Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5 1906

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
22 | 5 | 13 | \_\_\_\_\_

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

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 18 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-12-29 to 3-18-29, 1929, that I last saw her alive on 3-18, 1929, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Erysipelas  
1929 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? observation  
 (Signed) J. Bleck, M. D.  
3/19, 1929 (Address) Phil 4

\*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.

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Kansas

10. NAME OF FATHER William Dugan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Elizabeth Lee

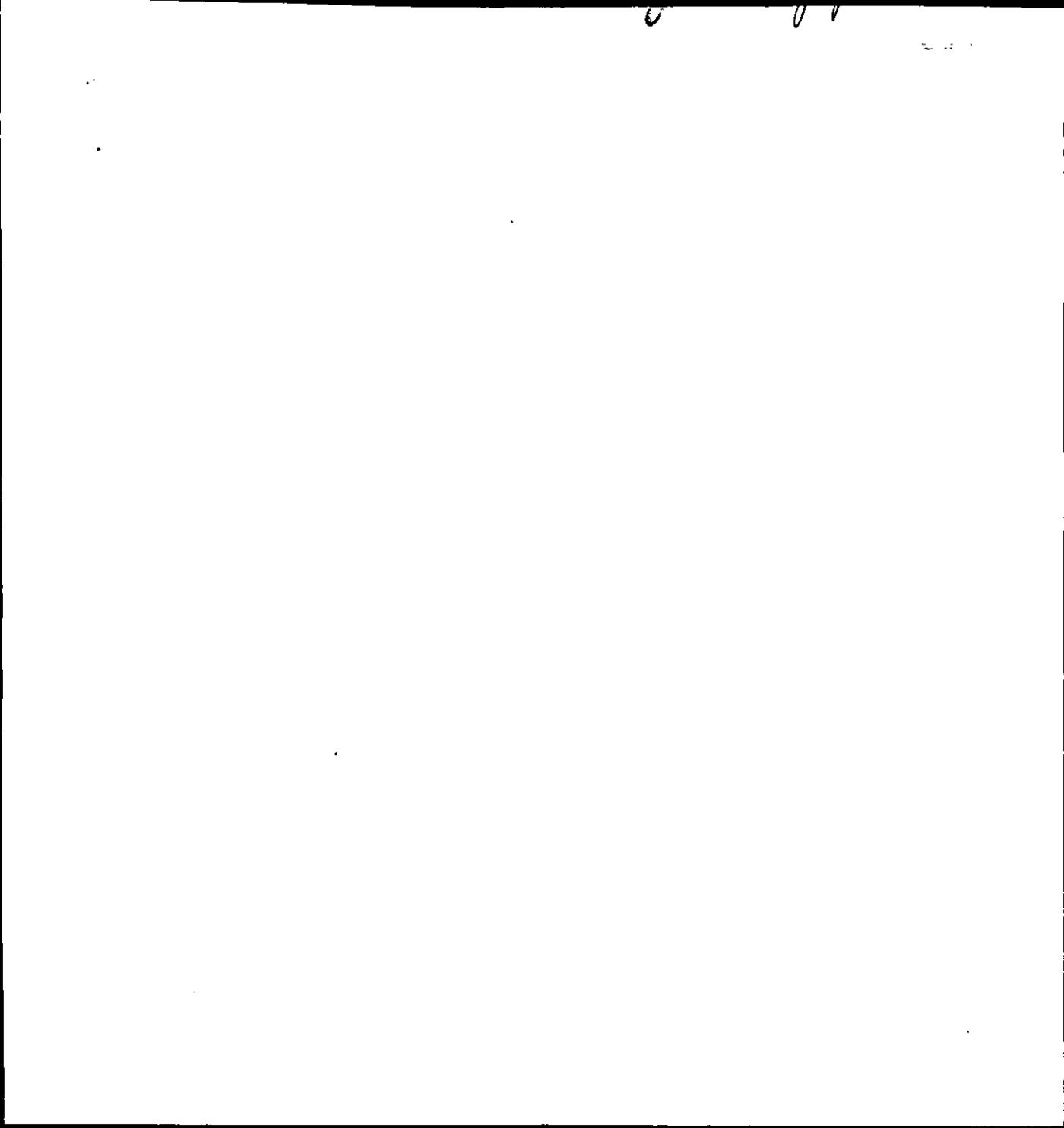
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Canada

14. INFORMANT James P. Fisher  
 (Address) 13619 Lexington

15. FILED 3/19 1929 M. M. Crowl  
 \_\_\_\_\_ REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Marcell DATE OF BURIAL Feb 21 1929

20. UNDERTAKER Mrs. C. L. Fauster ADDRESS K.C. Mo.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No. 399 File No.....  
 Township N. City Primary Registration District No. 2002 Registered No. 1361  
 City N. City (No. ....) St. .... Ward .....

**2. FULL NAME**

(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 F 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)

PARENTS

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 3/19 19 29 M. M. Grover REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/18 19 29

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

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Crushed  
caused by slight  
detraction of the nose

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

19

20. UNDERTAKER ADDRESS

REG. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

15891-S