

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

Do not use this space.

20500

File No. _____
Registered No. 117
City _____ St. _____ Ward _____

PERSONAL PARTICULARS OF DEATH

County Person Registration District No. 875
Township Washington Primary Registration District No. 6/62
City _____ (No. _____) _____ St. _____ Ward _____

2. FULL NAME Mellie D. Fisher
(a) Residence No. State Hospital # 3 St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. 7 mos. 16 ds. How long in U.S., if of foreign birth? yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) D.K. 1881
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ____ hrs. or ____ min. about 68 DK DK
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school teaching
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Windsor (STATE OR COUNTRY) Mo.
10. NAME OF FATHER not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) D.K. (STATE OR COUNTRY) D.K.
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) D.K. (STATE OR COUNTRY) D.K.

14. INFORMANT (Address) A. Fisher Windsor Mo.
15. FILE 6/5/29 E.R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1929
17. I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1925, to May 20, 1929, and that I last saw her alive on 4, 1929, and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
926
1077 (duration) 2 yrs. ____ mos. ____ ds.
CONTRIBUTORY Broncho pneumonia (SECONDARY) (duration) ____ yrs. ____ mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED? MO
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) J. T. O'Sell, M. D.
May 20, 1929 (Address) Nevada

*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 Windsor Mo DATE OF BURIAL 5/27/1929
20. UNDERTAKER Ferry Funeral Home Nevada ADDRESS _____

WRITE MAINLY, WITH UNFALTING TRUTH—THIS IS A PERMANENT RECORD

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.

MAINTAIN RESERVY FOR ENDINGS

881929

Ferry

