

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

Do not use this space.

15326

1. PLACE OF DEATH

County Boone
Township Ferick
City _____

Registration District No. 75
Primary Registration District No. 5174

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ruby May Fischer
(a) Residence Stocklandville, Mo. 1st 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5 - 1924

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
5 7 16

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 _____

9. BIRTHPLACE (CITY OR TOWN) Rowland Park
(STATE OR COUNTRY) Franklin Co. Mo.

10. NAME OF FATHER Alfred Fischer

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

12. MAIDEN NAME OF MOTHER Annie P. Phillips

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

14. INFORMANT Alfred Fischer
(Address) Rowland Park Mo.

15. FILE NO. 6-6, 1930 H. Gullett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1930

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1930 to May 21, 1930 that I last saw her alive on May 21, 1930, and that death occurred, on the date stated above, at 5:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diphtheria

10 (duration) yrs. mos. ds. 27

CONTRIBUTORY paralysis of larynx
(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) H. Gullett, M. D.

5-22-1930 (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 Columbian Cemetery DATE OF BURIAL 5-22-1930

20. UNDERTAKER W. H. Vandewater ADDRESS Calumet

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.

RECORD

