

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 7003

File No. 24753
Registered No. 6912
St. Ward)

2. FULL NAME

Julia Fischer

(a) Residence No. 3800 Shaw St. 18 Ward. (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. Female 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) July 18 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 11 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Traveling
(b) General nature of industry, business, or establishment in which employed (or employer). Hotel
(c) Name of employer British Hotel

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Delaware, Mo.

10. NAME OF FATHER

Alvin Fischer

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Victoria Handman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Germany

14. INFORMANT

Christine Fischer

(Address) 3800 Shaw

FILED JUL 14 1930

Max C. Stanley
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1930

17. I HEREBY CERTIFY, That I attended deceased from June 26 1930, to July 13 1930, that I last saw her alive on July 13 1930, and that death occurred, on the date stated above, at 11:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart failure due to Exophthalmic goiter
6 to 8 (duration) 10 yrs. mos. ds.

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

IF WHERE WAS DISEASE CONTRACTED Idiopathic
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes, DATE OF 6-13-30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. Ted Jean M. D.

*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 Delaware, Mo. DATE OF BURIAL July 16 1930

20. UNDERTAKER Bessie Gibson ADDRESS 138 No. 6

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.

