

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

Do not use this space.

3472

1. PLACE OF DEATH

County Sullivan
Township Gods
City Atkins

Registration District No. 852
Primary Registration District No. 6120

File No. 3
Registered No. _____
St. _____ Ward)

2. FULL NAME

Charles Madison Fish

(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. 45 mos. 45 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 21, 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 7 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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)

Sullivan Co., Missouri

10. NAME OF FATHER

Edmond Fish

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

New York

12. MAIDEN NAME OF MOTHER

Catherine Sostere

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

New York

14. INFORMANT (Address)

Elva Campbell
Green City, Mo.

15. FILED

1/18 1932
Bertha McClary
C.A. Schoere, Sub. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 17 19 32

17. I HEREBY CERTIFY, That I attended deceased from _____
I never saw _____, 19____,
that I last saw him _____ alive on _____ Jan, 19____, and that
death occurred, on the date stated above, at _____ 12 noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

We never did have a doctor.
From the evidence I believe he
had chronic nephritis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Epilepsy
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at his home in Green City.
He died in the Co. Infirmary where he
IF NOT AT PLACE OF DEATH. had been for six weeks

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? (1)

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. L. Karner - Co. Physician, M. D.

1/20, 1932 (Address) Milan, Mo.

*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

Green City Cem. Jan 18 19 32

20. UNDERTAKER

ADDRESS

Alexis E. Kent Green City.

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.

sent in 01 min. May we call Registrar 1932

