DEC 16 1937

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

Do not use this space.

1. PLACE OF DEATH

County Dent — Registration District No. 266 — File No. 41136

Township Short Bend — Primary Registration District No. 5377 — Registered No. 79

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Herbert Ernest Tischer

(a) Residence, No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12 1923

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	14 13	11	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. schoolboy

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo Mo

FATHER

13. NAME Herbert E. Tischer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Evansville Ind.

MOTHER

15. MAIDEN NAME Mary Louise Black

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan Ind.

17. INFORMANT (ADDRESS) Herbert Tischer 2333 David Ave Overland Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Overland Mo DATE Nov 24 1937

19. UNDERTAKER (ADDRESS)

20. FILED 11-22 1937 F. E. Butler M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 21, 1937

22. I HEREBY CERTIFY, That I attended deceased from — , 19—, to — , 19—

I last saw h— alive on — , 19— Death is said to have occurred on the date stated above, at 4:00 A.m.

The principal cause of death and related causes of importance were as follows:

Carbon Monoxide gas poisoning — Date of onset Nov 21 1937

Other contributory causes of importance: 178

Name of operation None Date of

What test confirmed diagnosis? Usual tests Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accidental Date of injury Nov 21, 1937

Where did injury occur? Short Bend Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. F. V. Trailer

Manner of injury Closed up in air tight trailer

Nature of injury Death caused by gas.

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) R. G. Dillon Coroner, M. D.

(Address) Salem, Mo.

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.

178

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

41136

Do not use this space.

1. PLACE OF DEATH

(a) County: Dent — Registration District No.: 266

(b) Township: Short Bend — Primary Registration District No.: 3377 — Registered No.:

(c) City: — (d) Street No.: — St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred: yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Herbert Ernest Tischer

(a) Residence, No.: St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	S

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.
	19	11	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.:

9. Industry or business in which work was done, as saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

FATHER

13. NAME:

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

MOTHER

15. MAIDEN NAME:

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY):

17. INFORMANT (ADDRESS):

18. BURIAL, CREMATION, OR REMOVAL

PLACE: DATE: 19

19. FUNERAL DIRECTOR (ADDRESS): Case Spencer, Salem, Mo.

20. FILED: 19 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Nov 21, 1937

22. I HEREBY CERTIFY, That I attended deceased from 19 to , 19

I last saw h. alive on , 19. Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carbon monoxide Gas Poisoning	

Other contributory causes of importance:

Name of operation: Date of:

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? accident Date of injury: Nov 21, 1937

Where did injury occur? Short Bend, Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. On highway

Manner of injury: Closed up in air tight trailer

Nature of injury: Death caused by gas.

24. Was disease or injury in any way related to occupation of deceased?

If so, specify:

(Signed) W. G. Dillon Coroner, M. D.

(Address) Salem Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No.....

(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME.....

(a) Residence, No..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

17. INFORMANT.....
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19....

19. FUNERAL DIRECTOR.....
(ADDRESS)

20. FILED..... 19.....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19

22. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
.....	
.....	
.....	
.....	
.....	

Other contributory causes of importance:

.....

.....

.....

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)..... , M. D.

(Address).....