

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

32437
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township SPRINGFIELD Primary Registration District No. 2001
 (c) or City SPRINGFIELD (d) Street No. Springfield Baptist Hospital Registered No. 739
 (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 Katharine Fisher
 (a) Residence, No. St. Dunnegan, Mo. (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 31, 1925
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
13 9 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 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) Panama West Cedar County MO
 13. NAME Katharine Fisher
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Panama West Cedar County MO
 MOTHER 15. MAIDEN NAME Panama West Cedar County MO
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
 17. INFORMANT (ADDRESS) Katharine Fisher Dunnegan Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Dunnegan Mo. DATE Oct 4, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank W. Barker Fair Play Mo.
 20. FILED Oct 7, 1939 Chas. H. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-4 1939
 22. I HEREBY CERTIFY, That I attended deceased from 10-4-39 to 10-4-39
 I last saw him alive on 10-4-1939 Death is said to have occurred on the date stated above, at 6:50 p.m.
 The principal cause of the death and related causes of importance were as follows:
Diphtheria
Post diphtheritic paralysis
of palate
Pneumonia
Cholelithiasis
Post infectious anemia
 Date of onset 9-15-39
 Other contributory causes of importance:
10
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no
 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? no
 If so, specify _____
 (Signed) Urban Busch, M. D.
 (Address) Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---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.

39
S
B

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Phyllis Jester
.....
working under my personal supervision.

....., Registered Apprentice No. *191*

Signed *Richard B. Ewin*

Licensed Embalmer No. *3092*

P. O. Address *Colonia MO*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

X