

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

35374  
Do not use this space.

NOV 19 1939

**1. PLACE OF DEATH**

(a) County AUDRAIN Registration District No. 26  
 (b) Township SALT RIVER Primary Registration District No. 3002  
 (c) City MEXICO Mo. (d) Street No. Audrain Hospital Registered No. 143  
 (e) Length of residence in city or town where death occurred yrs. mos. 3 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

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

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 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 William Fisher  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 26 1861  
 7. AGE YEARS 78 MONTHS 2 DAYS 15 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 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) Louisiana Mo.

FATHER 13. NAME (unknown), Kramer

FATHER 14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Holland

MOTHER 15. MAIDEN NAME Holland

MOTHER 16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Holland

17. INFORMANT (ADDRESS) Mrs. Butts, Vandalia Mo.

18. BURIAL, CREMATION, OR REMOVAL Middletown Mo. DATE Oct 13 1939

19. FUNERAL DIRECTOR (NAME) J. J. Waters

(ADDRESS) Vandalia Mo.

20. FILED Oct 13, 1939 Blanche Neely Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 11 - 1939

22. I HEREBY CERTIFY, That I attended deceased from 10 - 8 - 1939, to 10 - 11 - 1939.  
 I last saw him alive on 10 - 11 - 1939. Death is said to have occurred on the date stated above, at 10 P. m.

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

Intestinal obstruction Date of onset 4/6

Other contributory causes of importance:

Carcinoma of colon

Name of operation None Date of None  
 What test confirmed diagnosis: Clinical 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) Frank Jolley, M. D.

(Address) Mexico Mo.

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.

RECEIVED

District Health Officer No. 10

District File Number 11-29-1901

Date Filed NOV 8 1939

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,

Wm. B. Waters

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

Wm. B. Waters

Licensed Embalmer No.

3375

P. O. Address

Kendalia 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

35-374

Do not use this space.

1. PLACE OF DEATH

(a) County Andrain Registration District No. 26  
(b) Township..... Primary Registration District No. 3002 Registered No. 143  
(c) City Mexico (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 Edna Fisher

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
(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.  
78 2 15

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

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

MOTHER 15. MAIDEN NAME unknown

MOTHER 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 Oct 13 1939 Blanche Keely Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-11, 1939

22. I HEREBY CERTIFY, That I attended deceased from

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) J. Frank Jolley, M. D.

(Address) Mexico

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

SUPPLEMENTARY

