

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43993**
Registrar's No. **52**

Registration District No. **799** Primary Registration District No. **4479**

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Slater
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
217 N Walnut
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life _____ (Specify whether
years, months or days) 2

3. (a) PRINT FULL NAME JOHN J. FIZER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Lucinda Fizer 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>11</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Saline Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Jacob Fizer

18. Birthplace Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Martha Fizer

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Char F. Murphy

(b) Address Slater Mo

17. (a) Burial (b) Date thereof 12-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ocean Hill Saline Co Mo

18. (a) Signature of funeral director Harry Hornberger

(b) Address Marshall Mo

19. (a) 12/26/40 (b) W.M. Tuttle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Slater
(If outside city or town limits write "RURAL")
(d) Street No. 217 N Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
year 1940 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 12, 1940 to Dec 24, 1940
that I last saw him alive on Dec 24, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death General Arteriosclerosis with gangrene Right lower leg
Due to Chronic Myocarditis
Due to Chronic Nephritis

Other conditions (Include pregnancy within 3 months of death) 1781

Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 799
(Specify type of place) (While at work?) (e) Means of injury _____

23. Signature W.M. Tuttle (M. D. or other) _____
Address Slater, Mo. Date signed 12/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

77
8
1

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-13-41

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

Signed Kenneth Jackson
Licensed Embalmer No. 3954
P. O. Address Clinton 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.