S. No. 2
-1-4-41
-17-39
X2633

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15203

FILED MAY 11 1943

Registration District No. ~~[illegible]~~ 309

Primary Registration District No. ~~4454~~ 6050

Registrar's No. 5

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

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town Rural - Portage Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: West Alton, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 92

(c) City or town St. Charles County
(If outside city or town limits, write "RURAL")

(d) Street No. West Alton, Mo.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Joseph Fister

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary (Ernst) Fister

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June (Month) 15 (Day) 1853 (Year)

8. AGE: Years 89 Months 8 Days 11 If less than one day ..... hr. ..... min.

9. Birthplace Unknown (City, town, or county) — Germany (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Frank Fister
13. Birthplace ..... (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edw. Burns
(b) Address West Alton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 29-1943 (Month) (Day) (Year)
(c) Place: burial or cremation St. Francis Cem. Portage Des Sioux, Mo.

18. (a) Signature of funeral director H. C. Dallmeyer & Sons Co.
(b) Address 801 N. Second, St. Charles, Mo.

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1943 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from March 15 1941, to March 26 1943 that I last saw him alive on March 20 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Arteriosclerosis	20 years
Due to Senility	
Due to Hemiplegia	1 year
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury

23. Signature J. A. Barnard (M. D. or other)
Address Portage Des Sioux Date signed 4/4/43

(Licensed Embalmer's Statement on Reverse Side)

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 John E. Dallmeyer

Licensed Embalmer No. 2951

P. O. Address St Charles Mo

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

If this body is not embalmed, fact should be so stated above.

U. S. No. 2B
0M—8-21-41
MO I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15-203

Registration District No. 309 Primary Registration District No. 650 Registrar's No. 3-

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Joseph Fisher
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex .....
5. Color or race .....
6. (a) Single, widowed, married, divorced .....
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased June 15 - 1855 (Month) (Day) (Year)
8. AGE: Years ..... Months ..... Days ..... If less than one day hr. ..... min.
9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) Mar. 30 1948 (Date received local registrar) Rose Barnard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 2 Year 1943 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

S-15203