

FILED FEB 2 1944
Registration District No. **245A**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **General Hospital No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1-3-44-1-5-44**
In this community **Unknown 40 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2901 E. 54th St.**
(If rural, give location)
(e) Citizen of foreign country? **No** **n**own (Yes or No)
If yes, name country **Unknown**

3. (a) PRINT FULL NAME **WILLIAM A. FISHER**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **5**
year **44** hour **2:30** minute **P.M.**

4. Sex **Male** 5. Color or race **Negro**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Pearl Fisher**
6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **May 27 1890**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 3**
1944 to **January 5** 19 **44**
that I last saw him alive on **January 5** 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Phlegmon of penis with Uremia and Hydronephrosis** Duration

8. AGE: Years Months Days If less than one day
53 **7** **9** hr. min.

Due to **Urethral Stricture**

9. Birthplace **Independence Mo.**
(City, town, or county) (State or foreign country)

Due to **1360**

10. Usual occupation **Unemployed**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

Major findings: Of operations

MOTHER FATHER { 12. Name **James Fisher**

PHYSICIAN
Underline the cause to which death should be charged statistically.
Of autopsy **Same as above**

13. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

14. Maiden name **Kate M. Moss**
(City, town, or county) (State or foreign country)

15. Birthplace **Danville Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **General Hospital No. 2**

17. (a) **burial** (b) Date thereof **1/11/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **W. H. Brown**

(b) Address **1724 Lyden**

19. (a) **Jan 12 1944** (b) **W. H. Brown**
(Date received local registrar) (Registrar's signature)

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? Means of injury

23. Signature **W. H. Brown** (Date or other)

Address **New Hwy #2 600 E 22nd** Date signed **1/10/44**

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 *Jerome Maslove*
Licensed Embalmer No. *3994*
P. O. Address *2002 Highlan*

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

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