

Registration District No. 1002 Primary Registration District No. 1002

FILED MAR 9 1944

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

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether)

In this community 6 years
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. 1409 Harrison
(If rural, give location)

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

3. (a) PRINT FULL NAME Virginia Fisher

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Fe

5. Color or race wh

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

6. (b) Name of husband or wife Charles B. Fisher

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased: 10 (Month) 17 (Day) 1892 (Year)

8. AGE: Years 51 Months 4 Days 14 If less than one day 15 hr. _____ min. _____

9. Birthplace no (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation Housewife

11. Industry or business _____

12. Name Robert Laffoon

13. Birthplace Unstoun (City, town, or county) _____ (State or foreign country) _____

14. Maiden name Annie Quinn

15. Birthplace no (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant Chas. B. Fisher

(b) Address 1409 Harrison

17. (a) Burial (b) Date thereof 3-4-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director A. C. Dahlen

(b) Address 1415 715

19. (a) 3-2-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2nd
year 1944 hour 6 minute 50 A. M.

21. I hereby certify that I attended the deceased from February 28 1944, to March 2 1944; that I last saw her alive on March 2 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

Duration

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? _____

While at work _____ (Specify type of place)

(b) Means of injury _____

23. Signature A. E. Decker Med. Dir. M.D.
22 M. C. Cay (M. D. or other) _____
Address _____ Date signed _____

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 A. Mason

Licensed Embalmer No.

2646

P.O. Address

91415 East 15

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, fact should be so stated above.