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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 4021

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Audrain
(b) City or town Laddonia, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(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 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain
(c) City or town Laddonia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JANE MAGLINE FISCHER

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 12 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Frank Bernard Fischer
13. Birthplace Martinsburg Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Frances Bushnell
15. Birthplace Audrain Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Frank B Fischer
(b) Address Laddonia, Mo.

17. (a) burial (b) Date thereof May 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Laddonia, Mo.

18. (a) Signature of funeral director H. G. Krangiers
(b) Address Laddonia, Mo.

19. (a) 5-19-44 (b) J. W. Walters
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1944 hour 10 minute 15 P. M.

21. I hereby certify that I attended the deceased from May 18-44 8.30 P.M. 19____;
that I last saw her or alive on May 18-1944 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 24 hrs

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 107

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

23. Signature W. K. McCall (M. D. or other) _____
Address Laddonia Mo. Date signed 5-19-44

1080

(Licensed Embalmer's Statement on Reverse Side)

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

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

Baby not embalmed (family's request)

Registered Apprentice No.

working under my personal supervision.

Signed

H. G. Granger

Licensed Embalmer No.

81297

P. O. Address

Laddonia, N.Y.

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.