

FILED JAN 26 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1099

State File No.

85

Registration District No. 149

Primary Registration District No. 10.02

Registrar's No.

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 12-31-44-1-3-45
(Specify whether
In this community 8 yr.
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. 1414 E. 12
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME TREVIS FISHER

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

4. Sex male 5. Color or race Negro 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 July 29 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 5 34 hr. min.

9. Birthplace Atoka Oklahoma
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

12. Name Edward Fisher

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

14. Maiden name Gertrude Howell

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2.

17. (a) Burial (b) Date thereof 1-8-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director [Signature]

(b) Address 1819 E. 18th St. K.C. Mo

19. (a) 1-8-45 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 3
year 1945 hour 4:51 minute a. M.

21. I hereby certify that I attended the deceased from
December 31, 1944, to January 3, 1945;
that I last saw him alive on January 3, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Toxic Psychosis

Due to Lobar Pneumonia

Due to _____

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

Major findings: 108
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? _____

While at work? _____ (Specify type of place)
(f) Means of injury 3

23. Signature [Signature] (M.D. for doctor)

Address Gen. Hosp. #2-6006, 22 Date signed 1-5-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

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

Signed *John G. Flynn*

Licensed Embalmer No. *4383*

P. O. Address *1819 E. 15th Str K (M)*

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.