

S. No. 2
M-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7691**

FILED MAR 23 1945 **818** Primary Registration District No. **1003**
Registrar's No. **2273**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2603 N. Taylor Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 27 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2603 N. Taylor
(If rural, give location) 11
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert P. Fisher
(b) If veteran, name war ---
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 3d
year 1945 hour 10:45 minute P.M. M.

4. Sex Male 9
5. Color or race Negro
6. (a) Single, widowed, married, divorced, Widowed
(b) Name of husband or wife Matilda Fisher
(c) Age of husband or wife if alive -- years

21. I hereby certify that I attended the deceased from Mar 1 - 49 1945 to Mar 4 1945
that I last saw him alive on Mar 1 - 1945
and that death occurred on the date and hour stated above.

7. Birth date of deceased: April 5th 1855
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
89 10 28 hr. min.

Immediate cause of death
Valvular Heart Disease
Due to _____
Due to Chronic Nephritis

9. Birthplace Cloverport Kentucky /
(City, town, or county) (State or foreign country)
10. Usual occupation Barber (Retired)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 131
Of autopsy _____

11. Industry or business --
12. Name Unavailable
13. Birthplace Unavailable 9
(City, town, or county) (State or foreign country)
14. Maiden name Unavailable 9
15. Birthplace Unavailable 9
(City, town, or county) (State or foreign country)

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

16. (a) Informant Esther P. Hughes
(b) Address 2603 N. Taylor
17. (a) Burial (b) Date thereof 3-12-45
(Burial, cremation, ~~autopsy~~) (Month) (Day) (Year)

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? _____

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4105 Finney Ave.
19. (a) Washing (b) Date received 3-15
(Date received by registrar) (Year) (Registrar's signature)

While at work _____ (Specify type of place)
(a) Name of injury _____
23. Signature Samuel Jefford (M. D. or other)
Address 945 a N. Jefferson Date signed 3/8/45

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

Thomas J. Gages

working under my personal supervision.

Signed

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.