

S. No. 2
M-5-43
v. 5-17-39
p. I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26785

State File No. _____

FILED AUG 29 1945

Registration District No. _____

Primary Registration District No. 3006

Registrar's No. 207

1. PLACE OF DEATH:

(a) County: B. Boone

(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 28 Stanley St. 0
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Boone 10

(c) City or town: Columbia 2
(If outside city or town limits, write "RURAL")

(d) Street No.: 28 Stanley St. 4
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country: _____

3. (a) PRINT FULL NAME: STELLA FISHER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 11:30 minute _____ M.

21. I hereby certify that I attended the deceased from July 26
1945 to July 24 1945

that I last saw her alive on July 24 1945
and that death occurred on the date and hour stated above.

4. Sex: Female 3

5. Color or race: White

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

6. (b) Name of husband or wife: Clarence Fisher

6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: about 1880
(Month) (Day) (Year)

Immediate cause of death: General Paralysis

Due to: General Arterio-sclerosis

Due to: _____

8. AGE: Years Months Days If less than one day

about 65 - - - - hr. min.

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

Major findings: _____

Of operations: _____

Of autopsy: _____

9. Birthplace: Boone Mo. No. 0
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

MOTHER FATHER

11. Industry or business: _____

12. Name: Samuel Mitchell

13. Birthplace: Boone Mo. No. 0
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: _____ 4
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

97

16. (a) Informant: Clarence Fisher

(b) Address: Columbia Mo.

17. (a) Burial (b) Date thereof: 7-27-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Pyramid No.

18. (a) Signature of funeral director: Street P. Parker

(b) Address: Columbia Missouri

19. (a) 7-27-1945 (b) Edna H. Barber
(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: _____ (e) Means of injury: 0

23. Signature: Stephen D. Smith (M. D. or other) _____

Address: Columbia Mo. Date signed: 7-25/45

1250 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-16-45

STELLA FISHER

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.....

working under my personal supervision.

Registered Apprentice No.

Signed

Stewart P. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia Mo

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.