

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4986

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: 3037 Terrace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 20 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. 3034 Mercant
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William A. Fisher

3. (b) If veteran, name war no

3. (c) Social Security No. 492-18-8993

4. Sex Male 5. Color or race negro
6. (b) Name of husband or wife unknown
7. Birth date of deceased 2 11 1896
(Month) (Day) (Year)

6. (a) Single, widowed, married? widowed
6. (c) Age of husband or wife if alive _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 28 year 1945 hour 11 minute 50 P.M.

21. I hereby certify that I attended the deceased from Nov 29, 1945, to Nov 28, 1945

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Crownary thrombosis

Duration

Due to _____

Due to _____

Other conditions Injection pumps
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations 94a

Of autopsy none

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) _____ (Means of injury)

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date dictated Dec 19-1945

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

MOTHER FATHER

8. AGE: Years Months Days If less than one day
49 9 17 hr _____ min _____

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

10. Usual occupation Laborer

11. Industry or business Cerophyl Laboratories Inc.

12. Name John Fisher

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

14. Maiden name unknown

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

16. (a) Informant Bernice McCalwee

(b) Address 816 Montana

17. (a) Burial (b) Date thereof 12-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn F. C. Home

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

(b) Address 440 State

19. (a) 12-4-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

Albritton

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

Eugene English

Licensed Embalmer No. *441-215*

P. O. Address *440 State Ave K.C.*

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.