

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12643

FILED MAY 8 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 156

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution:
State Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 days (Specify whether years, months or days)

In this community 36 days (Specify whether 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. 1723 1/2 Woodland
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME ANDREW C FISHER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife Nettie Fisher

6. (c) Age of husband or wife if alive O.K. years

7. Birth date of deceased. Sept 8 18??
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>9</u>	<u>17</u>	hr. min.

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

10. Usual occupation None

11. Industry or business O.K.

MOTHER FATHER

12. Name John Fisher

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

14. Maiden name O.K.

15. Birthplace O.K. 9
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address State Hospital No. 1, Fulton Mo

17. (a) Burial (b) Date thereof Apr. 30-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Walter C. ...

(b) Address 1729 Lippin Ave K.C. Mo

19. (a) Apr 29-47 (b) Josie Morrison
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1947 hour 6:00 minute P M.

21. I hereby certify that I attended the deceased from 20 March
1947 to 25 April 1947;
that I last saw him alive on 25 April 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary T. B

Due to _____

Due to _____

Other conditions General arteriosclerosis
(include pregnancy within 3 months of death)

Major findings: and cardiac enlargement

Of operations _____

Of autopsy 3B

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? 0

While at work? _____ (Specify type of place)

Means of injury Dr. A. Ferguson by Dr. H. W. ...

Signature Dr. A. Ferguson (M. D. or other) M.D.

Address State Hospital No. 1 Date Apr 29 1947

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

4
1
2

5-7-47

District No. Number

District Health Office No. 9

RECEIVED

AUG 21 1947
JUN 07 1947
AUG 9 1947

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, ~~by~~.....

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

Signed Eli Bell.....

Licensed Embalmer No. 2130.....

P. O. Address Fulton, 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: