

5. No. 2
M-5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17036

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 86

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington
(c) Name of hospital or institution: St. Francis
(d) Length of stay: In hospital or institution 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Franklin
(c) City or town Robertsville
(d) Street No. _____
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Leona Jane Fisher
(b) If veteran, name war _____
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day fourth
year 1947 hour 7 minute 45 M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Thos Fisher
(c) Age of husband or wife if alive 65 years
7. Birth date of deceased: (Month) 2 (Day) 1886 (Year)

21. I hereby certify that I attended the deceased from 5-26-47 to 6-4-47
that I last saw her alive on 6-4 and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months 3 Days 26 If less than one day _____ hr. _____ min.

Immediate cause of death Intestinal Obstruction
Due to Ventral Hernia

9. Birthplace Grey Summit Mo
10. Usual occupation House wife

Other conditions Arteriosclerotic Cardis Vascular Disease
Due to _____

11. Industry or business _____
12. Name John Perry Jones
13. Birthplace Crawfords Mo
14. Maiden name Corra Cass
15. Birthplace North Carolina

Major findings: Of operations _____
Of autopsy 172A

16. (a) Informant Thos Fisher
(b) Address Robertsville Mo
17. (a) Burial (b) Date thereof 6 6 47
(c) Place: burial or cremation Brush Creek Cemetery
18. (a) Signature of funeral director Craig & Davis
(b) Address St Clair Mo
19. (a) JUN 5 1947 (b) _____

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
23. Signature BJ Stehlik (M. D. or other) M.D.
Address Union, Mo Date signed 6-5-47

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

6
16
10

Date Recd. April 9 1947
District File Number

District Health Officer No. 9,
RECEIVED

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

H. M. Land

Licensed Embalmer No.

3601

P. O. Address

St. Clair, 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.