

No. 2
5-43
5-17-39
X 36871

FILED NOV 6 1948/9

State File No. _____
Registrar's No. 4245

Registration District No. 1/19 Primary Registration District No. 1002

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: General Hospital No. 1 D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 60 YEARS
years, months or days)

3. (a) PRINT FULL NAME Robert W. Fischer
3. (b) If veteran, name war NO 3. (c) Social Security No. NO ONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. PEARL FISCHER 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased DECEMBER 19 1879
(Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace DES MOINES IOWA
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business HARNESSES MAKEP

MOTHER FATHER { 12. Name ROBERT FISCHER 4
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name ERNSITINE SCHNIDER
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)?

16. (a) Informant MRS. PEARL FISCHER

(b) Address 3222 SOUTH BENTON

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT-19-1948
(Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. W. Newcomer

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 10-19-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3222 So. Benton
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16
year 1948 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from Oct. 11, 1948, to Oct. 16, 1948
that I last saw h im alive on Oct. 16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Senile psychosis-Intestinal obstruction
Due to strangulated hernia

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

Major findings: Of operations 1220
Of autopsy See above

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? Wm. W. Hart (Specify type of place) (e) Means of injury _____
23. Signature Wm. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 10-18-48

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

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

Dr. Lockwood

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..... *Bernard L. Moran*

Licensed Embalmer No. *425-0*

P. O. Address..... *MC 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.