

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8929

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

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BIRTH NO. _____		REG. DIST. NO. <u>159</u>		PRIMARY REG. DIST. NO. <u>2249</u>		Registrar's No. <u>11</u>	
1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>JEFFERSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>HILLSBORO</u>		c. LENGTH OF STAY (In this place) <u>4</u> <u>3 wks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CEDAR HILL</u>		50 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedar Grove Nursing Home</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LOUIS</u>		b. (Middle) _____		c. (Last) <u>FISCHER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 6 - 1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>OCT. 4 - 1865</u>	
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>25</u>		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>CEDAR HILL MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>THOMAS FISCHER</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>WILHELMINA BOEHLING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter W Fischer HOUSE SPRINGS-MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of prostate</u> ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchopneumonia, right lower lobe</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 1949</u> , to <u>April 7, 1949</u> , that I last saw the deceased alive on <u>April 6, 1949</u> , and that death occurred at <u>1 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Thomas A. Donnell M.D.</u>				23b. ADDRESS <u>Desoto, Mo.</u>		23c. DATE SIGNED <u>4-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4/9/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>LOCAL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>CEDAR HILL MO</u>	
DATE REC'D BY LOCAL REG. <u>4-8-49</u>		REGISTRAR'S SIGNATURE <u>Kathleen Marston</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Frank Summer House Springs Mo</u>			

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed APR 13 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

John H. Brimmer

Signed _____

Student Embalmer

Licensed Embalmer No. 1476

P. O. Address House Spring 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.