

FILED MAR 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7285**

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **23**

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston,	c. LENGTH OF STAY (in this place) 4 Month	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston, Missouri 1602	d. STREET ADDRESS (If rural, give location) 1212 Maud St.
d. FULL NAME OF HOSPITAL OR INSTITUTION 1212 Maud Street		d. STREET ADDRESS 1212 Maud St.	

3. NAME OF DECEASED a. (First) STEVE b. (Middle) FISHER, c. (Last) JR. (Type or Print) Stone Forrest			4. DATE OF DEATH (Month) (Day) (Year) February 17 1950
---	--	--	--

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) XXXXXXX	8. DATE OF BIRTH June 26 1949	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 7 Days 22	IF UNDER 2 HRS. Hours 1 Min.
--------------------	---------------------------------	---	--------------------------------------	--	--	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX	10b. KIND OF BUSINESS OR INDUSTRY XXXXXXX	11. BIRTHPLACE (State or foreign country) East St. Louis, Ill.,	12. CITIZEN OF WHAT COUNTRY? U.S.
---	--	--	--

13a. FATHER'S NAME STEVE FISHER, SR. Robert Forrest	13b. MOTHER'S MAIDEN NAME Rosa Lee Jones	14. NAME OF HUSBAND OR WIFE JAMES XXXXXXXXXXXXXXXXXXXX
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) XXXX XXXXX	16. SOCIAL SECURITY NO. XXXXX	17. INFORMANT'S SIGNATURE OR NAME Robert Forrest ADDRESS 1212 Maud St.
--	--------------------------------------	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 3 *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) Bilateral Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days
	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.		100%

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 **2/15, 1950**, to **2/17, 1950**, that I last saw the deceased alive on **2/17, 1950**, and that death occurred at **9:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE John R. Samble M.D. (Degree or title)	23b. ADDRESS 1209 Maud St Sikeston Mo	23c. DATE SIGNED Feb 20
---	--	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-4-50	24c. NAME OF CEMETERY OR CREMATORY Booker Washington	24d. LOCATION (City, town, or county) (State) East St Louis Ill
---	-------------------------	---	--

DATE REC'D BY LOCAL REG. Feb 18-50	REGISTRAR'S SIGNATURE Mrs Ella Hunter	429	25. FUNERAL DIRECTOR'S SIGNATURE Red Smith ADDRESS 1212 Maud St Sikeston, Mo
---	--	-----	--

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

MAR 10 1950

APR 11 1950

RECEIVED

MAR 6 1950

District Health Office No.

District File Number 350-18

Date Filed

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.

Student
Student Embalmer

Signed *Fred J. Smith*

Licensed Embalmer No. *4408*

P. O. Address *Slipstone, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF VITAL STATISTICS

7285
23

State of Illinois }
County of St. Clair } ss.

State File No. _____
Local Registrar's No. _____

AFFIDAVIT FOR CORRECTION OF A RECORD

On this 11th day of March, 1950, before me appears Rosia Lee James Fisher, who, upon her oath, states that the original record of ^{birth} death for Stene Forrest (nee Steve Fisher), died February 17, ~~born~~ 1950, in the State of Missouri, and which was filed at Sikeston, Mo. on 2-18- 1950, should be corrected as follows:

Item No. 3 should read Steve Fisher, Jr.

Instead of Stene Forrest

Item No. 13a should read Steve Fisher, Sr.

Instead of Robert Forrest

Item No. 13b should read Rosia Lee James

Instead of Rosia Lee Jones

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

Item No. _____ should read _____

Instead of _____

The above is true to the best of my knowledge, information and belief

(SEAL) Affiant Rosia Lee James Relationship. _____

1503 South I Street
Present Address.

Subscribed and sworn to before me this 11th day of March, 1950.

My Commission expires August 9, 1952 _____
Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.