

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36549**

No. 300
10.48 FILED DEC 8-1951

BIRTH NO. _____		REG. DIST. NO. 47	PRIMARY REG. DIST. NO. 3008	Registrar's No. 337
1. PLACE OF DEATH a. COUNTY CALLOWAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Calloway		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FULTON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fulton 0143		
d. FULL NAME OF HOSPITAL OR INSTITUTION Calloway Co. Hospital		d. STREET ADDRESS (If rural, give location) 839 Westminister		
3. NAME OF DECEASED (Type or Print) FRED		a. (First) FISHER	b. (Middle)	c. (Last)
4. DATE OF DEATH (Month) (Day) (Year) Nov-29th 1951				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH June 7-1895	9. AGE (In years last birthday) 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mine	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME George Fisher		13b. MOTHER'S MAIDEN NAME Frances Hill	14. NAME OF HUSBAND OR WIFE Nannie Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Lillian Jackson ADDRESS Mexico Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pung Abscess ANTECEDENT CAUSES Pemphigema 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* Lobar pneumonia Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 mo 3 mo May 1951
19a. DATE OF OPERATION 10-15-51		19b. MAJOR FINDINGS OF OPERATION Reoperation. Pemphigema Solid P. Lung.		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 490x	
22. I hereby certify that I attended the deceased from 10-13 , 19 51 , to Death , that I last saw the deceased alive on 11-27 , 19 51 , and that death occurred at 10A m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) John J. Brown MD		23b. ADDRESS Fulton	23c. DATE SIGNED 11-30-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/2/51	24c. NAME OF CEMETERY OR CREMATORY Fulton	24d. LOCATION (City, town, or county) (State) Fulton Mo.	
DATE REC'D BY LOCAL REG. Dec-1-1951	REGISTRAR'S SIGNATURE Martha Lawrence	426	25. FUNERAL DIRECTOR'S SIGNATURE Stuart J. Parker ADDRESS Columbia Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

0143
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File No. _____
DISTRICT HEALTH OFFICE No. 4

DEC 3 1951

RECEIVED

DEC 27 1951

JAN 29 1963

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 *Stuart P. Parker*

Licensed Embalmer No. *2900*

P. O. Address *Columbia, 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.