

Health,  
Welfare  
Public  
Service

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28236  
STATE FILE NUMBER  
149 Primary Registration District No. 1002 Registrar's No. 3804

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300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Woodward Nursing Home</u> Length of stay in lb <u>50 yr.</u>		d. STREET ADDRESS <u>609 E. 9<sup>th</sup></u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MAY</u> Last <u>FISHER</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1880</u>	9. AGE (In years at birthday) <u>76</u>	10. UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	11. UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>	11. BIRTHPLACE (City and state or country) <u>Ceredo, West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Wm. Feazel</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Hunt</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas C. Fisher</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, & unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mr. Howard Jones</u> Address <u>4755 B. Russell St. Louis 14, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs. ago (m.m.a.)</u> <u>895678</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Post-operative kidney</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>47</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION <u>Kansas City, Mo.</u> COUNTY _____ STATE <u>Mo.</u>
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21. I attended the deceased from <u>April 7</u> to <u>Sept 12</u> and last saw her alive <u>Aug 10/57</u> ✓ Death occurred at <u>Aug 12, 1957</u> on the date stated above and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>James T. Ferguson, M.D.</u> (Degree or title)	22b. ADDRESS <u>410 Bryant Bldg</u>	22c. DATE SIGNED <u>Aug 12/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug 14 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Liberty, Missouri</u>
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24. FUNERAL DIRECTOR <u>C. D. Blackman &amp; Son Inc</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8-14-57</u>	26. REGISTRAR'S SIGNATURE <u>Reva Trinsball</u>
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N.C. Mo.  
(Licensed Embalmer's Statement on Reverse Side)

James T. Ferguson  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.  
Decay, color, etc. must use only standard nomenclature in item 18. No symptoms will be listed.



1-1330

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 .....  
Signature of Student Embalmer

Signed *W.C. Reine* .....

Licensed Embalmer No. *4879* .....

P. O. Address *K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.