

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40327
 STATE FILE NUMBER
 5398

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5398

S. 300
 v. 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>Kansas</u> b. COUNTY <u>JOHNSON</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>Overland Park</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>Menorah Medical Center</u>		Length of stay in 1b <u>2 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>10120 Nall Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>UNDERWOOD</u> Last <u>Fisher</u>			4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1895</u>	9. AGE (In years last birthday) <u>62 yrs</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRANCH MANAGER PARK-DAVIS & CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	11. BIRTHPLACE (City and state or country) <u>CHICAGO, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN A. FISHER</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA JOHNSON</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. JEAN M FISHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>486-05-0009</u>	17. INFORMANT Address <u>10120 NALL AVENUE</u> <u>OVERLAND PARK, KANSAS</u>		
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>pulmonary infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>lung hemorrhage</u> DUE TO (c) <u>pulmonary edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>Hypertensive</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>444X.</u>
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.)			
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 COUNTY STATE	
21. I attended the deceased from <u>1951</u> to <u>11-12-57</u> and last saw her/him alive on <u>11-12-57</u> . ✓ Death occurred at <u>2:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>William Lowe Mundy, M.D.</u> (Degree or title)			22b. ADDRESS <u>1103 brand</u>		22c. DATE SIGNED <u>11-12-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>NOV-15-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-21-57</u>	26. REGISTRAR'S SIGNATURE <u>Wend Minshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

William Lowe Mundy use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



mt 2-4075

DEC 5 1957

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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *47 E 32nd A*

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.