

MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1959

59-024197

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 775

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 2 days	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 810 South 23rd St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Francis Middle Leonard Last Fisher			4. DATE OF DEATH Month July Day 29 Year 1959			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1921	9. AGE (last birthday) 38	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CB & Q Trainman	10b. KIND OF BUSINESS OR INDUSTRY Trainman	11. BIRTHPLACE (City and state or country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Frank L. Fisher	13b. MOTHER'S MAIDEN NAME Mary Jilge	14. NAME OF HUSBAND OR WIFE Vera Fisher
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-18-9436	17. INFORMANT Mrs. Vera Fisher Address
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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) Suicide Cerebral Eclama		INTERVAL BETWEEN ONSET AND DEATH About 55 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Leg 2 Internal Carotid Artery Thrombosis		About 6 hrs
	DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE
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21. I attended the deceased from July 27, 1959 to July 29, 1959 and last saw her alive on July 29, 1959 Death occurred at 12:30 P.M. on the date stated above, and to the best of my knowledge from the causes stated.	
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22. SIGNATURE (Degree or title) George W. Forman M.D.	22b. ADDRESS 902 Edmund St. St. Joseph, Mo.	22c. DATE SIGNED 7-30-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/1/1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR Heaton Bowman	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. July 31, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF G. W. Forman, Medical Certification

VS OCT 1 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

William J. ...

Licensed Embalmer No. 4535

P. O. Address *St. Joseph St*

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.