

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000833

LED VS JAN 14 1960

STATE FILE NUMBER

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 1-1960

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba</u>		c. CITY OR TOWN <u>Cuba</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT Home</u>		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Burrell</u> Last <u>Fishwick</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1960</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>Sept 25 1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>ST. Louis MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>FRANK Fishwick</u>		13b. MOTHER'S MAIDEN NAME <u>MAY WATSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS MARGARET Fishwick Cuba, mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Congestive Failure</u>			<u>Months</u>
DUE TO (b) <u>Prolonged chronic congestive failure</u>			<u>years</u>
DUE TO (c) <u>Chronic cardiovascular</u>			<u>years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Localized Echinocystic cysts of face</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" 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.)
20c. TIME OF INJURY Hour <u>9:30</u> Month <u>Sept</u> Day <u>59</u> Year <u>60</u>		

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 <u>Cuba</u>	COUNTY <u>Cuba</u>	STATE <u>mo.</u>
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21. I attended the deceased from Sept 59 to 2 Jan 60 and last saw her/him alive on 1 Jan 60
Death occurred at 9:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Gordon W. Biffel MD</u> (Degree of Title)	22b. ADDRESS <u>Bourbon, mo.</u>	22c. DATE SIGNED <u>8 Jan 60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 7 1960</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Kinder</u>	23d. LOCATION (City, town, or county) (State) <u>Cuba mo.</u>
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24. FUNERAL DIRECTOR <u>Norman & Heener</u>	ADDRESS <u>Cuba, mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-4-1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Faint, mostly illegible text at the top of the page, possibly containing names and dates.

JAN 14 1960

STATEMENT BY LICENSED EMBALMER MAR 11 1960

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 Norman C. Hoe
Licensed Embalmer No. 4673

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.