

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-021960

Registration District No. 231 Primary Registration District No. 4342 Registrar's No. 30

STATE FILE NUMBER

AMENDED
FILED JUN 27 1961

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BEAR CREEK</u>		c. CITY OR TOWN <u>4 1/2 Miles Northwest</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS <u>9 Jonesburg</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>FISCHER</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>61</u>	
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>1-17-78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Germany</u>
13a. FATHER'S NAME <u>Wm. Ernst Fischer</u>		14. NAME OF HUSBAND OR WIFE <u>St Louis mo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT <u>Anne Watt</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>Bronchial pneumonia</u> <u>Liposarcoma cut of by</u> <u>Wedge Melastoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>6 weeks</u>
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

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		

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 Sept 1, 1961 to June 16, 1961 and last saw her him alive on June 16, 1961
Death occurred at 1:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>James O. Helm MD</u> (Degree or title)	22b. ADDRESS <u>New Florence mo</u>	22c. DATE SIGNED <u>6-20-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>6-19-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jonesburg</u>
24. FUNERAL DIRECTOR <u>Carl Harding</u> ADDRESS <u>Jonesburg</u>		23d. LOCATION (City, town, or county) (State) <u>Jonesburg Mo</u>

25. DATE RECD. BY LOCAL REG. <u>6-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Laura B Callaway</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Carl A. Harding

Licensed Embalmer No. 4115

P.O. Address Jonesburg, 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.