

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH,
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020071

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2872 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED JUN 3 1963

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City Length of stay in lb 35 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4501 East 39th. St. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) 4501 East 39th. St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First ALFRED Middle - Last FISHER 4. DATE OF DEATH Month 5 Day 17 Year 1963

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 11-20-11 9. AGE (last birthday) 51 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder 10b. KIND OF BUSINESS OR INDUSTRY Welding 11. BIRTHPLACE (City and state or country) Brookfield, Missouri 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Thomas Fisher 13b. MOTHER'S MAIDEN NAME Ollie Sprague 14. NAME OF HUSBAND OR WIFE Grace Copeland Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2 17. INFORMANT Address K.C., Mo.
Mrs. Grace Fisher; 4501 East 39th. St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory failure
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Open heart surgery 1952. Aortic Aneurysm
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 _____ to _____ and last saw her alive on _____ Death occurred at 12:31 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Hugh H. Owens 22b. ADDRESS 152 Union Station 22c. DATE SIGNED 5-20-63 (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 5-22-63 23c. NAME OF CEMETERY OR CREMATORY National Cemetery 23d. LOCATION (City, town, or county) Fort Leavenworth, Kansas

24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES (S) K.C., MO. ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 5-20-63 26. REGISTRAR'S SIGNATURE P. Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

JUN 13 1963

JUN 1 1963

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,

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack T. Moore

Licensed Embalmer No. 4729

P. O. Address Terre Haute, 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.

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