

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038537

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 8 1963

Primary Registration District No. 2072

Registrar's No. 143

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 0975  
2 0970  
3  
4 /  
5 /  
6  
7 0  
8 0  
9 332X  
10  
11  
12 1-0  
13 30

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Marshall</i>		Length of stay in lb <i>8 days</i>	c. CITY OR TOWN <i>Clay Township</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Fitzgibbon Hospital</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>5 miles south of Gilliam, Mo.</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lillian (none) Fischer</i>			4. DATE OF DEATH Month Day Year <i>October 4, 1963</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>May 23, 1889</i>
9. AGE (last birthday) <i>74</i>		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) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Saline City, Mo.</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13a. FATHER'S NAME <i>Jesse Hensick</i>	
13b. MOTHER'S MAIDEN NAME <i>Belle Neff</i>		14. NAME OF HUSBAND OR WIFE <i>Frank Fischer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of <i>no</i> )		17. INFORMANT Address <i>Frank Fischer, RR #2, Slater, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> DUE TO (b) <i>Arteriosclerosis, Hemiplegia</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <i>Jan 1961</i> to <i>Oct. 1961</i> and last saw her <i>alive</i> on <i>10-4-63</i> Death occurred at <i>2:30 AM</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert W. Stahl</i>		22b. ADDRESS <i>Marshall, Missouri</i>	22c. DATE SIGNED <i>10-4-63</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Oct. 6, 1963</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arrow Rock, Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Arrow Rock, Missouri</i>
24. FUNERAL DIRECTOR ADDRESS <i>Haines Funeral Home, Slater, Missouri</i>		25. DATE RECD. BY LOCAL REG. <i>10-4-63</i>	26. REGISTRAR'S SIGNATURE <i>Carl G. Reed</i>

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

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 Walter J. Haines, Jr.

Licensed Embalmer No. 4557

P. O. Address Alatou, 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.