

MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 1327

67 30042605

STATE FILE NUMBER

DO NOT WRITE
ON THIS SUB

AMENDED

VS 300
Rev. 4/59

1 5117

2 5117

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

R. Maginn MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED NOV 27 1967

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in lb <u>10 Years</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1107 Church St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>GERTRUDE</u> Last <u>FISHER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1967</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>7-10-1880</u>
9. AGE (last birthday) <u>87</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (City and state or country) <u>Cosby, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Pankau</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Kimett</u>	
14. NAME OF HUSBAND OR WIFE <u>Paul Joseph Fisher</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.		17. INFORMANT Address <u>Mrs Rosa Hausman 2615 S. 17th St. Josep</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>Hypostatic pneumonia</u> DUE TO (b) <u>Uremia- nephritis</u> DUE TO (c) <u>Generalized arteriosclerotic cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr</u> <u> yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </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		COUNTY STATE	
21. I attended the deceased from <u>5-9-57</u> to <u>11-18-67</u> and last saw her alive on <u>11-18-67</u> Death occurred at <u>11:00a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. Maginn</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>M.D. 702 Jules Street St. Joseph, Missouri</u>	
22c. DATE SIGNED <u>11-20-67</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>11-21-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Hurlingen, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>H.O.Sidenfaden & Son</u>		ADDRESS <u>St. Joseph, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>11-24-67</u>		26. REGISTRAR'S SIGNATURE <u>Mary Vallentine</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

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 Robert H. Gable

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.