

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

11233

1. PLACE OF DEATH

County..... Registration District No. 78
 Township..... Primary Registration District No. 003
 City St. Louis (No. City Hospital #2) St. 3063 Ward)

2. FULL NAME

Renderson Fisher
 (a) Residence. No. 2211 Franklin St. 71 Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maggie Fisher

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>ad</u>	<u>26</u>	<u>?</u>	<u>?</u>	<u>—</u>

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Verny Fisher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT (Address) Anna H. Woodard
City Hospital #2

15. FILED APR 11 1928 maub Staroff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13, 1928
 17.

I HEREBY CERTIFY, That I attended deceased from 3/6, 1928 to 3/13, 1928
 that I last saw her alive on 3/13, 1928, and that death occurred, on the date stated above, at 5:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic hypochromic
131
935

independent (duration) yrs. mos. ds.
Chronic nephritis

CONTRIBUTORY (SECONDARY) 1990 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? at home
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....

19. WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Chronic
 (Signed) John H. Hoop M.D.

, 19 (Address) City Hospital #2

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Washington Park DATE OF BURIAL Mar 22, 1928

20. UNDERTAKER Wm. Purdy ADDRESS 4125 Finney

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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