

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

Do not use this space.
13745

Janette

1. PLACE OF DEATH
 County *Jefferson* Registration District No. *25*
 Township *Centre* Primary Registration District No. *4019*
 City *Marion* St. _____ Ward _____

2. FULL NAME *Janette Fischback*
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *4* yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** *Married*
 (write the word)
5A. (IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *O. V. Fischback*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 15th 1903*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>23</i>	<i>3</i>	<i>21</i>	

8. OCCUPATION OF DECEASED *House wife*
 (a) Trade, profession, or particular kind of work
 (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) *Marion Mo*

10. NAME OF FATHER *Arthur Roberts*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Marion Mo*

12. MAIDEN NAME OF MOTHER *Bertha Wells*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Jefferson Mo*

14. INFORMANT (Address) *Arthur Roberts
Marion Mo*

15. FILED *46* 19*24* *USA Admed*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 6 1924*

17. I HEREBY CERTIFY That I have *seen* deceased from _____ to _____
 that I last saw him *alive* on _____ 19*24* and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) *31*
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED *State Mo*
 IF NOT AT PLACE OF DEATH, DATE OF _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) *USA Admed*, M. D.
 (Address) *Marion Mo*

*State the DISEASE CAUSING DEATH, or in 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 *Marion Mo* **DATE OF BURIAL** *4-9 1924*

20. UNDERTAKER *W B Wells* **ADDRESS** *Marion Mo*

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.

MARGIN RESERVE

