

REGD APR 17 1939

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

9678
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395
 (b) Township Kaw Primary Registration District No. 1007
 (c) City K. C. Mo. (d) Street No. St. Mary's Hospital Registered No. 1284
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

260 Miss Mary T. Fischer

(a) Residence, No. 3833 Chestnut St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22, 1854
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
84 9 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Data deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

FATHER 13. NAME George Fischer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

MOTHER 15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

17. INFORMANT (ADDRESS) Mrs. Anna E. Ewing
3833 Chestnut

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Mar. 27, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John W. Wagner
K. C. Mo.

20. FILED Mar 24 1939 M. M. Browe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 1st 1939 to Mar 23, 1939
 I last saw her alive on Mar 23, 1939. Death is said to have occurred on the date stated above, at 11:00 P.M.
 The principal cause of death and related causes of importance were as follows:

Myocardial Degeneration

Other contributory causes of importance: 930

Name of operation Influenza Date of now
 What test confirmed diagnosis now Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? now Date of injury
 Where did injury occur? now (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury now
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify now
 (Signed) A. P. Lawrence M.D.
 (Address) 714 7/8 Bryan St.

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES

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

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, above space should be left blank.