

Registration District No. 121

Primary Registration District No. 3009

1. PLACE OF DEATH:

(a) County Cape Girardeau Co.  
 (b) City or town Cape Girardeau  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Luke East Missouri Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1-21-40 to -  
 In this community 1-26-40  
 years, months or days (Specify whether)

8. (a) PRINT FULL NAME Mrs Meta Fischer

8. (b) If veteran, name war no  
 8. (c) Social Security No. no

4. Sex Female 5. Color or race Cauc  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife as Walker Fischer  
 6. (c) Age of husband or wife if alive 33 years  
 7. Birth date of deceased July 15-1909  
 (Month) (Day) (Year)

8. AGE: Years 31 Months 6mo Days 11 If less than one day hr. min.

9. Birthplace Newellville Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business no

MOTHER FATHER  
 12. Name Martin Mangels  
 13. Birthplace Fralna Mo  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Millie Vogel  
 15. Birthplace Fralna Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Albert Miller  
 (b) Address Cape Girardeau - Mo

17. (a) Bury (b) Date thereof Jan 28-40  
 (Burial, cremation or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Suth. Cemetery at Fralna

18. (a) Signature of funeral director Yount & Sons  
 (b) Address Perdueville Mo  
 19. (a) 1-26-40 (b) John Thompson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Fralna (b) County Perry - Mo  
 (c) City or town Fralna - Mo  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-26-40 day \_\_\_\_\_  
 year \_\_\_\_\_ hour 1:30 P.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1-21-40  
Jan 21, 1940, to 1-26-, 1940  
 that I last saw her alive on Jan 25, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
General septic peritonitis  
 Due to ruptured suppurative appendicitis  
 Due to \_\_\_\_\_  
 Duration 1/17/40

Other conditions (Include pregnancy within 3 months of death)  
 Major findings: septic general peritonitis, ruptured suppurative gangrenous appendix  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature G. R. DeWitt (M. D. or other)  
 Address Cape Girardeau, Mo Date signed \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

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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**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 *Edward C Young*

Licensed Embalmer No. *2138*

P. O. Address *Coryville 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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1916  
Do not use this space.

1. PLACE OF DEATH

(a) County Cape G. Registration District No. 125  
(b) Township Cape G. Primary Registration District No. 3009 Registered No. 42  
(c) City Cape G. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(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

Mrs Meta Fischer  
(a) Residence, No. \_\_\_\_\_ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26, 1940

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 15, 1909

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
30 6 11

The principal cause of death and related causes of importance were as follows:

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER  
13. NAME \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER  
15. MAIDEN NAME \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

Specify whether injury occurred in industry, in home, or in public place.

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_

20. FILED 2-8, 1940 J. M. Thompson Local Registrar.

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) G. B. Schulz, M. D.

(Address) Cape G. Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

SUPPLEMENTARY

