

Registration District No. 464

Primary Registration District No. 5626

54  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**  
 (a) County. Lafayette  
 (b) City or town. Rural, - Washington Twp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community. Ten Years  
 years, months or days)

**3. (a) PRINT FULL NAME.** Ruth Jane Fizer 260  
**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_  
**4. Sex.** Fe **5. Color or** W **6. (a) Single, widowed, married,**  
**race.** W **divorced.** WIDOW  
**6. (b) Name of husband or wife.** \_\_\_\_\_ **6. (c) Age of husband or wife if**  
 alive. \_\_\_\_\_ years  
**7. Birth date of deceased.** Aug. 2. 1863  
 (Month) (Day) (Year)

<b>8. AGE:</b>	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>19</u>	_____ hr. _____ min.

**9. Birthplace.** Saline Co. Missouri  
 (City, town, or county) (State or foreign country)

**10. Usual occupation.** at home

**11. Industry or business.** \_\_\_\_\_

**MOTHER FATHER**  
**12. Name.** William McClelland  
**13. Birthplace.** Missouri  
 (City, town, or county) (State or foreign country)  
**14. Maiden name.** Jane Nell  
**15. Birthplace.** Missouri  
 (City, town, or county) (State or foreign country)

**16. (a) Informant.** R.L. Fizer  
**(b) Address.** Higginsville, Mo.

**17. (a) Burial** (b) Date thereof Feb. 25, 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation.** Mt. Tabor Cem. Odessa

**18. (a) Signature of funeral director.** R. C. Schorley  
**(b) Address.** Odessa, Mo.

**19. (a) 2-22-40** (b) Thos E. M. Goodwin  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State. Missouri (b) County. Lafayette  
 (c) City or town. Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Washington Township  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Feb day 21  
 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ P. M.  
**21. I hereby certify that I attended the deceased from** June 12  
1937 to Feb 21st 1940  
 that I last saw her alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

**Immediate cause of death.** Coronary Arteriosclerosis  
Hypertension  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
**Major findings:** \_\_\_\_\_  
 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 \_\_\_\_\_

**23. (a) Where did injury occur?** \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

**23. Signature.** R. C. Schorley (M. D. or other) \_\_\_\_\_  
**Address.** Odessa, Mo. Date signed 2/23/40

RECEIVED

RECEIVED  
Public Health Officer No. 8  
Date Filed 3/6/40  
File Number

**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 George L. Keenan

Licensed Embalmer No. 7541

P. O. Address Olson, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 464

Primary Registration District No. 3626

Registrar's No. \_\_\_\_\_

1. PLACE OF BIRTH:

(a) County Lafayette  
(b) City or town Washington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Ruth Jane Fizer

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 76 Months 5 Days 19 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Apr - 9 - 1948 (Date received local registrar) Mrs E. M. Sorensen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 Feb day 21 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature R.C. Schoen (M. D. or other) \_\_\_\_\_

Address Adessa Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-7155