

FILED OCT 13 1944

Registration District No. 137

Primary Registration District No. 3028

Registrar's No. 199

1. PLACE OF DEATH:

(a) County JASPER
 (b) City or town CARTHAGE
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rose Convalescent Home - 519 E 3rd
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 months
 (Specify whether
 In this community 2 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Jasper 49
 (c) City or town CARTHAGE 1
 (If outside city or town limits, write "RURAL")
 (d) Street No. 519 E. 3rd 3
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country U.S.A.

3. (a) PRINT FULL NAME

HARVEY FISHELL

(b) If veteran, name war none

(c) Social Security No.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Y
 (b) Name of husband or wife Permelia Stephens Fishell 6. (c) Age of husband or wife if alive 5 years
 7. Birth date of deceased October 5 1897
 (Month) (Day) (Year)

8. AGE: Years 66 Months 10 Days 27 If less than one day
 hr. min.

9. Birthplace Charleston Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation RAILROAD CREWMAN

11. Industry or business retired

MOTHER FATHER
 12. Name Pete Fishell
 13. Birthplace Unknown CANADA
 (City, town, or county) (State or foreign country)
 14. Maiden name CERIA Holloway
 15. Birthplace unknown MISSOURI
 (City, town, or county) (State or foreign country)

16. (a) Informant Rose Convalescent Home
 (b) Address 519 E 3rd - Carthage Mo

17. (a) Burial (b) Date thereof Sept 6 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director KNEEL MORTUARY
 (b) Address CARTHAGE, Mo.

19. (a) Sept. 5 '44 (b) E. Elizabeth Couplin
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
 year 1944 hour 1:15 minute a.M.

21. I hereby certify that I attended the deceased from 19 to 19;
 that I last saw the deceased at home and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Due to two previous attacks

Other conditions §30
 (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
 (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? Yes (Specify type of place) (c) Means of injury Boat
 23. Signature P. A. Webster (M. D. or other) Boat
 Address Carthage, Mo. Date signed Sept 1, 44

1283

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

44-10-828

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.....

Emmal Stuep

Licensed Embalmer No.....

391

P. O. Address.....

Carthage

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, fact should be so stated above.

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(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)

3. (a) PRINT FULL NAME Harvey Fishell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 0 1900
(Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct. 17 '1944 (b) Elizabeth Couplin
(Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him/her alive on _____, 19____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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 _____

(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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

31120