

Registration District No. 5

Primary Registration District No. 5026

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Albion
(b) City or town Rural Clark
(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.
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt
(c) City or town Corning
(d) Street No.
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME DOROTHY VIOLA FISK

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

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 1928
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
16 1 24 hr. min.

9. Birthplace Near Rock Port Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School girl

11. Industry or business School

12. Name Baron E. Fisk

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

14. Maiden name Medda Loan Bowen

15. Birthplace Near Rock Port Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. W. R. Bowen

(b) Address Corning, Missouri

17. (a) Burial (b) Date thereof 5/18/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funer. Hall near Rock Port

18. (a) Signature of funeral director Thos. H. Schaefer

(b) Address Fairfax, Missouri

19. (a) May 19 1945 (b) Thos. H. D. Cunningham
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 16
year 1945 hour 6 minute 20 P.M.

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

Immediate cause of death
COMPLETE FRACTURE OF SKULL
Due to TRUCK ACCIDENT

Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. Of autopsy.
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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) ACCIDENT 003
(b) Date of occurrence MAY 16 - 1945
(c) Where did injury occur 2 MI. E. FAIRFAX RICHMON MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
ROAD
While at work? No (Specify type of place) (e) Means of injury 3
23. Signature Thos. H. D. Cunningham (Date signed) 5-16-45
Address Westford Mo

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

300

FEB 14 1947

FEB 18 1947

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.

RECEIVED

District Health Officer No. 11,

District File Number

Date Filed

Signed... *Harvin H. Schoeler*

Licensed Embalmer No. *4162*

P. O. Address *Fairfax, Missouri*

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. 5

Primary Registration District No. 5026

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Rural Clarkburg
(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 Dorothy Ursula Fink

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 5

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

7. Birth date of deceased May 22 1922
(Month) (Day) (Year)

8. AGE: Years 17 Months 1 Days 14 (Unless 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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(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 May 1945 year. 10 hour. 15 minute. M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Crushed skull
by accident

Due to Truck in which she was riding struck

Due to tree on Highway 275, 2 mi. south of

Other conditions: Additional Supplemental Information Requested
(Include pregnancy within 9 months)

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 5-16-45

(c) Where did injury occur? Fairfax, Atchison MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 275
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Dr. Thos F Fay Corcoran

Address Westboro Date signed 6-15-45

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

16177