

0. 2
8-13
7-39
X37823

FILED JUN 24 1946

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 136

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

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 3 wks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown Central Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles F. Fischer

(b) If veteran, name war no

(c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1946 hour 12 minute 50 P.

21. I hereby certify that I attended the deceased from May 15, 1946
to 6-7-46

that I last saw him alive on 6-6-
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer prostate

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced wid 2

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 5 months of death) _____

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>			hr. _____ min. <u>9</u>

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

10. Usual occupation Unk

Major findings:

Of operations _____

Of autopsy 51k

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business

12. Name unk

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

14. Maiden name unk

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

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 W. O. McKnelly (M. D. or other) _____
Address Jefferson City, Mo. Date signed 6-8-46

16. (a) Informant unk Police Dept

(b) Address unk Jefferson City, Mo

17. (a) Removal Removal
(Burial, cremation, or removal)

(b) Date thereof June 19, 1946
(Month) (Day) (Year)

(c) Place: burial or cremation: Kirksville, Mo

18. (a) Signature of funeral director Victor Buescher

(b) Address Jefferson City, Mo

19. (a) 6-8-46 (Date received local registrar)

(b) R.P. Davis MD (Registrar's signature)

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 6-21-46

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 Victor Buesche

Licensed Embalmer No. 3701

P. O. Address Jefferson City, 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, fact should be so stated above.

Registration District No. 77 Primary Registration District No. 3016

1. PLACE OF DEATH:
(a) County cole
(b) City or town Jefferson city
(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 Charles F. Fischer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hr. _____ 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 6-28-46 (b) R.P. Dennis M.D.
(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 _____ Year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

19830