

No. 2
-2-43
5-17-39
X35697

FILED AUG 27 1946

State File No. _____

Registrar's No. 188

Registration District No. 77

Primary Registration District No. 3016

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

1. PLACE OF DEATH:

(a) County Cole

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

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

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) Less than one day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston 59

(c) City or town Chillicothe
(If outside city or town limits, write "RURAL") 2

(d) Street No. 401 Calhoun
(If rural, give location) 1

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

3. (a) PRINT FULL NAME William Brooks Fisher

3. (b) If veteran, name war World War III

3. (c) Social Security No. 499-20-1274

4. Sex M 0

5. Color or race W

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased May 3 1924
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
22	3	11	hr. min.

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

10. Usual occupation Student

11. Industry or business _____

MOTHER FATHER

12. Name Frank E. Fisher

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

14. Maiden name Grace Anderson

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

16. (a) Informant Mr. Lewis Anderson

(b) Address Chillicothe, Missouri

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

(b) Date thereof 8/15/46
(Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, Mo.

18. (a) Signature of funeral director Clyde Morton

(b) Address _____

19. (a) 8-14-46 (Date received local registers)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August Day 14th
year 1946 hour _____ minute _____ M.

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

Immediate cause of death: depressed
Stenose fracture left
side of skull 2 1/2
Due to auto accident

Duration _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION

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 76

(b) Date of occurrence Aug 13 1946
(City or town) (County) (State)

(c) Where did injury occur? Highway 50
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 50.

While at work? No (Specify type of place)

(e) Means of injury Auto accident

23. Signature J.P. Leslie MD Coroner 3
Address Jefferson City, Mo Date signed 8-23-46

8-23-46 Held for Coroner's Office

RECEIVED
District Health Officer No. 9,
District File Number 8-46-901
Date Filed 8-24-46

FEB 14 1947

SEP 3 1946

NOV 14 1946

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 Vernon M. Morten

Licensed Embalmer No. 4125

P. O. Address Lin., 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. *79*

Primary Registration District No. *2016*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town *cole 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 *Wm B. Fisher*

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 *s*

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

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

8. AGE: Years *22* Months *3* Days _____
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (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 _____ Day _____
year *1946* (hour) _____ minute _____ M. *4*

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 *Wm B Fisher was riding in an automobile. This auto struck an auto transport truck or a vehicle used to transport new autos.*
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
1700
y/n

Duration _____

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*
(b) Date of occurrence *Aug 14 - 1946*
(c) Where did injury occur *on highway 50 Orage mo*
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on highway 50

While at work? _____ (Specify type of place)
() Means of injury *Auto, truck transport*

23. Signature *J. Leslie* (M. D. or other) _____

Address *Jefferson City mo* Date signed *8-30-46*

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

SUPPLEMENTARY

25487

200041

NOV 14 1946

FEB 14 1947