

Registration District No. **146**

Primary Registration District No. **3026**

Registrar's No. **71**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Independence**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Independence Sanitarium & Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **22 Days**  
(Specify whether  
In this community **8 Months**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Independence**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1022 East Lexington**  
(If rural, give location)  
(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **ANNIE FISHER**  
3. (b) If veteran, name war  
3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **February** day **22**  
year **1948** hour **12** minute **20** A. M.

4. Sex **Female** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive  
7. Birth date of deceased **April 7, 1863**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **7/21**, 19**47**, to **2/27**, 19**48**  
that I last saw him **alive** on **2/27**, 19**48**,  
and that death occurred on the date and hour stated above.  
Duration **2 1/2 hrs.**

8. AGE: Years **84** Months **10** Days **15**  
If less than one day hr. min.

Immediate cause of death **Bronchopneumonia**  
Due to **Fracture of rt hip** **3 wks**  
Due to

9. Birthplace **Brant, Ontario, Canada**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Housewife**

Other conditions **arteriosclerosis**  
(Include pregnancy within 3 months of death) **yes**

11. Industry or business  
12. Name **John Weidendorf**  
13. Birthplace **Canada**  
(City, town, or county) (State or foreign country)  
14. Maiden name **No Data**  
15. Birthplace **Canada**  
(City, town, or county) (State or foreign country)

Major findings: **fx rt hip**  
Of operations **ADD: SUPP: INFOR: REQU: 120V**  
Of autopsy **—**

16. (a) Informant **Mrs. Ida Tordoff McClain**  
(b) Address **Independence, Missouri**  
17. (a) **Burial** (b) Date thereof **2/24/48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) Place: burial or cremation **Floral Hills**  
18. (a) Signature of funeral director **Roland R. Speaks**  
(b) Address **Independence, Missouri**  
19. (a) **2-24-48** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature)

23. Signature **Vance E. Lusk, M.D.** (M. D. or other)  
Address **Independence, Mo** Date signed **2/23/48**

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

MOTHER FATHER

1948  
MAY 6

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 *Poland R. Speaks*  
Licensed Embalmer No. 3604

P. O. Address Independence, 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. March  
Registrar's No. 71Registration District No. 146 Primary Registration District No. 3026

## 1. PLACE OF DEATH

(a) County Jackson  
(b) City or town Independence  
(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 Annie Fisher

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 \_\_\_\_\_

7. Birth date of deceased April (Month) 7 (Day) 1948 (Year)8. AGE: Years 84 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)9. Birthplace Canada (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 \_\_\_\_\_ (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 \_\_\_\_\_  
(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 Feb 2  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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) accident(b) Date of occurrence 1/31/48(c) Where did injury occur? Independence, Jackson, Mo  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
HomeWhile at work? no (Specify type of place) (e) Means of injury Fall23. Signature Vance E. Lieb, M.D. (M. D. or other)Address Independence, Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-5187-1948