

FILED SEP 25 1948

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Menorah Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether  
61 Years  
In this community \_\_\_\_\_  
years, months or days)

3: (a) PRINT FULL NAME FREDERICK G. FISCHER

3: (b) If veteran, name war No 3: (c) Social Security No. None

4. Sex M 5. Color or race White 6: (a) Single, widowed, married, divorced Widowed  
6: (b) Name of husband or wife Anna A. Fischer 6: (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug. 18, 1866 1866  
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 0 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Washington, D. C.  
(City, town, or county) (State or foreign country)

10. Usual occupation Patent Attorney

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Frederick Fischer  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace New York 1  
(City, town, or county) (State or foreign country)

16: (a) Informant Lewis J. Fischer

(b) Address 911 Westport Road

17: (a) Burial (b) Date thereof 9-20-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18: (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19: (a) 9-18-48 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 49  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 911 Westport Road  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18  
year 48 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 9/17 to 9/18 1948  
that I last saw him alive on 9/18 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure Duration 3 days  
arteriosclerotic heart disease years  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Chronic Anemia ?  
(Include pregnancy within 3 months of death)

Major findings: Of operations 93 d PHYSICIAN \_\_\_\_\_  
Of autopsy \_\_\_\_\_ 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)  
Means of injury \_\_\_\_\_  
23. Signature Willa [unclear] (M. D. or other) \_\_\_\_\_  
Address 720 Bryant St Date signed 9/18/48

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

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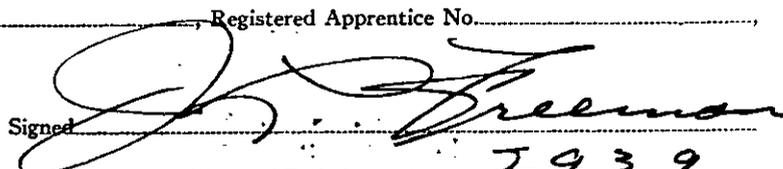
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**STATEMENT BY LICENSED EMBALMER**

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



Licensed Embalmer No. 2939

P. O. Address F. O. 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.**