

No. 300
10. 48

FILED JUN 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 190377

BIRTH NO. 55-128-48 REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5353 Registrar's No. 48

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

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dallas</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FAIRGROVE RURAL</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fairgrove rural</u> | |
| c. LENGTH OF STAY (in this place) <u>life</u> | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS | |

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|--|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>MARILYN</u> b. (Middle) <u>Kay</u> c. (Last) <u>Fischer</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 12 - 1949</u> | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | |
| 8. DATE OF BIRTH <u>Aug 30 - 1948</u> | | 9. AGE (Years) (Months) (Days) <u>9 12</u> | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>0</u> | | 13a. FATHER'S NAME <u>Gerald Fischer</u> | | 13b. MOTHER'S MAIDEN NAME <u>Helma Kirk</u> | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT'S SIGNATURE OR NAME <u>Gerald Fischer</u> | | ADDRESS <u>Fairgrove, Mo.</u> | | | |

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|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Coronary Heart - Septal infarct</u> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septal defect</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | DUE TO (b) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | DUE TO (c) | | 7544 | |

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|---|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 6-12, 1949, to 6-14, 1949, that I last saw the deceased alive on 6-12, 1949, and that death occurred at 6-14, 1949 m., from the causes and on the date stated above.

| | | | | | |
|--|--|---|--|--|--|
| 23a. SIGNATURE <u>G. L. Jones, Jr.</u> (Degree or title) | | 23b. ADDRESS <u>609 North St. Springfield Mo.</u> | | 23c. DATE SIGNED <u>6/14/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>6-14-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Hope Well Cemetery</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>Dallas County Mo.</u> | | DATE REC'D BY LOCAL REG. <u>6/18/49</u> | | REGISTRAR'S SIGNATURE <u>Mr. B. Jones</u> 80 | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>B. Jones</u> | | ADDRESS <u>Buffalo, Mo.</u> | | | |

(Licensed Emballer's Statement on Reverse Side)

RECEIVED

District Health Officer No. _____

District File Number 5-49

Date Filed 6-20-46

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Mario B. Jones

Signed _____
Student Embalmer

Licensed Embalmer No. 4322

P. O. Address Buffalo 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.