

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1949

State File No.

No. 300

10-48

BIRTH NO. _____		REG. DIST. NO. <u>10</u>		PRIMARY REG. DIST. NO. <u>5087</u>		Registrar's No. <u>143</u>	
1. PLACE OF DEATH a. COUNTY <u>Audrain</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Audrain</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural Salt River Twp.</u>		c. LENGTH OF STAY (in this place) <u>4 mos</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Salt River Twp.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>RFD #3, Highway Inn</u>				d. STREET ADDRESS (If rural, give location) <u>RFD#3, Highway Inn.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CYNTHIA</u>		b. (Middle) <u>AVEN</u>		c. (Last) <u>FISCHECK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 14 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Apr 4, 1949</u>	
9. AGE (In years last birthday) <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Mexico, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Oliver W. Fischbeck</u>		13b. MOTHER'S MAIDEN NAME <u>Ava Taylor</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>O.W. Fischbeck</u> ADDRESS <u>Missouri</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Enteritis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Colon Bacillus</u> DUE TO (c) <u>Mal-nutrition</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>5710</u>	
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 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 <u>Aug 13, 1949</u> , to <u>Aug 14, 1949</u> , that I last saw the deceased alive on <u>Aug 13, 1949</u> , and that death occurred at <u>8 A m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>R. W. Van Thyn</u>		23b. ADDRESS <u>Medico Mo.</u>		23c. DATE SIGNED <u>8-15-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Aug 15, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Roodhouse, Illinois</u>		24d. LOCATION (City, town, or county) (State) <u>Illinois</u>	
DATE REC'D BY LOCAL REG. <u>Aug 15-1949</u>		REGISTRAR'S SIGNATURE <u>Blanche Neely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chris Bruce</u>		ADDRESS <u>Medico Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 22 1949
District Health Officer No. 10
District File Number 8-49-1445
Date Filed AUG 22 1949

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 _____

Charles J. Greening

Signed _____
Student Embalmer

Licensed Embalmer No. 4625

P. O. Address Mexico 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.