

FILED MAR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7698

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 285

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Nebraska b. COUNTY Richardson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 1 Month	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mrs. Leon Nursing Home 624 Prospect Ave.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Falls City 8260	
3. NAME OF DECEASED (Type or Print) Martha Ann Fisher		d. STREET ADDRESS (If rural, give location) Not given 8	
a. (First)		b. (Middle)	
4. DATE OF DEATH March 8, 1950		c. (Last)	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 10, 1872
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Falls City, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Charles Wyatt	
13b. MOTHER'S MAIDEN NAME Rebecca Forney		14. NAME OF HUSBAND OR WIFE Harry A. Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ***** None	
17. INFORMANT'S SIGNATURE OR NAME Mr. Harry A. Fisher		ADDRESS Falls City, Nebraska	
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) myocardial failure ANTECEDENT CAUSES (b) chronic hypertension Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 4222	
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) (Min.)	
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 _____, 1950, to _____, 1950, that I last saw the deceased alive on _____, 1950, and that death occurred at 6:00 A.M., from the causes and on the date stated above.			
23a. SIGNATURE W. M. Daethaler, M.D. (Degree or title)		23b. ADDRESS St. Joseph, Mo.	
23c. DATE SIGNED 3/8/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Mar. 9, 1950		24c. NAME OF CEMETERY OR CREMATORY Steele Cemetery	
24d. LOCATION (City, town, or county) Falls City, Nebraska		24e. (State)	
DATE REC'D BY LOCAL REG. Mar 13, 1950		REGISTRAR'S SIGNATURE C. G. Jenkins 382	
25. FUNERAL DIRECTOR'S SIGNATURE Walter Meierhoffer		ADDRESS 1946 Colhoun St. St. Joseph, Mo.	

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, of*****

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Albert R. Harrington

Licensed Embalmer No. 3258 Missouri.

P. O. Address St. Joseph, 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.