

No. 300
10.48

FILED JUL 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20888

State File No.

BIRTH NO. _____ REG. DIST. NO. 257 PRIMARY REG. DIST. NO. 5881 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY OSAGE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY OSAGE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL (Jefferson Town-		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural (Jefferson Township)	
c. LENGTH OF STAY (In this place) 66 yrs		d. STREET ADDRESS (If rural, give location) North of Belle, Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION family home			

3. NAME OF DECEASED (Type or Print) JACOB	a. (First)	b. (Middle)	c. (Last) FLEISCHMAN	4. DATE OF DEATH 6-28-51	(Month) (Day) (Year)
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5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH MARCH 13-1878	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Fleischman	13b. MOTHER'S MAIDEN NAME Barbara Weller	14. NAME OF HUSBAND OR WIFE #####
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Henry Fleischman - Belle, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 years
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		DUE TO (b) _____		177X
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Dec., 1950, to June, 1951, that I last saw the deceased alive on 6-28, 1951 and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE R. M. Keller M.D.	(Degree or title)	23b. ADDRESS Chilwensville, Mo.	23c. DATE SIGNED 6-30-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-1-1951	24c. NAME OF CEMETERY OR CREMATOR Koenig Methodist	24d. LOCATION (City, town, or county) (State) Osage County, Missouri
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DATE REC'D BY LOCAL REG. July 3, 1951	REGISTRAR'S SIGNATURE R. D. ...	25. FUNERAL DIRECTOR'S SIGNATURE Sabmann Funeral Service, Belle	ADDRESS Belle
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. _____
DISTRICT HEALTH OFFICE No. 4

JUL - 9 1951

RECEIVED

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.

Student
Student Embalmer

Signed Chester Saunier

Licensed Embalmer No. 4178

P. O. Address Bland - 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.