

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4241**

FILED MAR 8 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **55** PRIMARY REG. DIST. NO. **3011** Registrar's No. **157**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> b. CITY OR TOWN <b>Carrollton</b> c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Atwood Hosp.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before institution). a. STATE <b>Mo.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN <b>Rural</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <b>P.F.D. #4</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>CHARLES - FISCHER</b> a. (First) b. (Middle) c. (Last)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 28 1954</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Never Married</b>	<b>8. DATE OF BIRTH</b> <b>Jan. 17 1874</b>
<b>9. AGE</b> (In years last birthday) <b>80</b> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1/2 YRS.: Hours _____ Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>
<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Pickawa Co. Ohio</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>John Fischer</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Christine Beher</b>	
<b>14. NAME OF HUSBAND OR WIFE</b> <b>None</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Wm F. Heus</b>	
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Broncho pneumonia</b> <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Parkinson Disease, Diabetes mellitus</b> DUE TO (c) _____ <b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>350 X</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>18. INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>	<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)
<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>Feb 21</u>, 19<u>54</u>, to <u>Feb 28</u>, 19<u>54</u> that I last saw the deceased alive on <u>Feb 28</u>, 19<u>54</u>, and that death occurred at _____ m., from the causes and on the date stated above.</b>			
<b>23a. SIGNATURE</b> (Degree or title) <b>William B. Atwood M.D.</b>		<b>23b. ADDRESS</b> <b>Carrollton Mo.</b>	<b>23c. DATE SIGNED</b>
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>24b. DATE</b> <b>3-2-54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Hill Cem.</b>	<b>24d. LOCATION (City, town, or county) (State)</b> <b>Carrollton Mo.</b>
<b>DATE REC'D BY LOCAL REG.</b> <b>3/2/54</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Mr. Herbert</b>	<b>455</b> <b>GENERAL DIRECTOR'S SIGNATURE</b> <b>Carroll Standley Gibson</b>	<b>ADDRESS</b> <b>Carrollton Mo.</b>

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ben W. Gibson*

Licensed Embalmer No. *2961*

P. O. Address *Carrollton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.