

FILED MAY 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11270**

BIRTH NO. _____ REG. DIST. NO. 5 PRIMARY REG. DIST. NO. 3011 Registrar's No. 45

1. PLACE OF DEATH a. COUNTY CARROLL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CARROLL <u>0170</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CARROLLTON <u>0</u>		c. CITY OR TOWN CARROLLTON	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>0</u>
c. LENGTH OF STAY (in this place) <u>7</u> Days		e. STREET ADDRESS (If rural, give location) RURAL 8 miles South East	
d. FULL NAME OF HOSPITAL OR INSTITUTION ATWOOD HOSF.			

3. NAME OF DECEASED (Type or Print)	a. (First) CHRISTINE	b. (Middle) ELIZABETH	c. (Last) FECHER	4. DATE OF DEATH (Month) (Day) (Year) APRIL 28 1955
-------------------------------------	-----------------------------	------------------------------	-------------------------	------------------------------------------------------------

5. SEX FE.	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT. 16, 1898	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
-------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	------------------------	------------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and State or Foreign Country) HOWELL COUNTY <u>0</u>	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--------------------------------------------------------------------------------------------------------------	-----------------------------------------------	----------------------------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME JOSEPH DOWLING	13b. MOTHER'S MAIDEN NAME JOHANNA PETERS	14. NAME OF HUSBAND OR WIFE LEO FECHER
------------------------------------------	-------------------------------------------------	-----------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	17. INFORMANT'S SIGNATURE OR NAME MR. LEO FECHER	ADDRESS CARROLLTON, MO.
--------------------------------------------------------------------------	----------------------------------------------------------------------------	---------------------------------------------------------	--------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION: I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 56 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 331 X	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from April 26, 1955, to April 28, 1955 that I last saw the deceased alive on April 28, 1955, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Ewald L. Smith M.D.	23b. ADDRESS 2029 5th St. Carrollton, Mo.	23c. DATE SIGNED 4-29-55
-----------------------------------------------------------------	--------------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE APRIL 30 1955	24c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM.	24d. LOCATION (City, town, or county) (State) CARROLLTON, MO.
---------------------------------------------------------	--------------------------------	-----------------------------------------------------------	----------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 4/29/55	REGISTRAR'S SIGNATURE Mr. Herbert Calver	45	25. FUNERAL DIRECTOR'S SIGNATURE Stanley J. Gibson	ADDRESS Carrollton, Mo.
-----------------------------------------	-------------------------------------------------	----	-----------------------------------------------------------	--------------------------------

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

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... *Barrolla*

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.