

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **43416**

FILED JAN 6 1958

BIRTH NO. _____ REG. DIST. NO. **10** PRIMARY REG. DIST. NO. **4020** Registrar's No. **384**

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Mo b. COUNTY Andrew	
b. CITY OR TOWN Martinsburg		c. CITY OR TOWN Martinsburg	
d. FULL NAME OF HOSPITAL OR INSTITUTION At Home		f. STREET ADDRESS (If rural, give location) 6040	

3. NAME OF DECEASED (First) GEORGE (Middle) BERNARD (Last) FISCHER			4. DATE OF DEATH (Month) DEC (Day) 18 (Year) 1957		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July-14-1873	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 5 Days 7	IF UNDER 24 Hrs. Hours _____ Min. _____
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10. USUAL OCCUPATION (Give kind of work concerning most of working life even if retired) Mail Clerk	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Don't know	13b. MOTHER'S MAIDEN NAME Mary Ann Huff	14. NAME OF MARRIAGE CERTIFICATE George Fischer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Marion Fischer ADDRESS Martinsburg Mo
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility		
	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? 2 YES <input type="checkbox"/> NO <input checked="" 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) 794 X (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ m. _____	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 14, 1957**, to **Dec 16, 1957**, that I last saw the deceased alive on **Dec 14, 1957**, and that death occurred at **5:30 PM** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter H. Walls MD	23b. ADDRESS Wellsville Mo	23c. DATE SIGNED 12/19/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/20/57	24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	24d. LOCATION (City, town, or county) Martinsburg Mo (State) _____
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DATE REC'D BY LOCAL REG. Dec 19-57	REGISTRAR'S SIGNATURE Blanche Neely	25. FUNERAL DIRECTOR'S SIGNATURE A B Thibault ADDRESS Wellsville Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9-0

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, *A. B. Wells*.....

Licensed Embalmer No. *15,888*

P. O. Address *Hallsville Va*

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.