

FILED DEC 23 1957

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 141

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Brookfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <u>Doctor's Hospital</u>		Length of stay in lb <u>30 minutes</u>	d. STREET ADDRESS (If outside, give location) <u>2509 Lilly</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Christian</u> Last <u>Fishback</u>			4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 25, 1898</u>	9. AGE (In years last birthday) <u>59</u>	10. FUNDER 1 YEAR Months <u>9</u> Days <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wendt-Sonia</u>	11. BIRTHPLACE (City and state or country) <u>Frankford, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Willie E. Fishback</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth Christian</u>		14. NAME OF HUSBAND OR WIFE <u>Elizabeth Fishback</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>490-07-6570</u>		17. INFORMANT <u>Elizabeth Fishback, Hannibal, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute traumatic death</u> DUE TO (b) <u>Injuries sustained in two car accident.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 to 5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Two car auto accident.</u>			
20c. TIME OF INJURY <u>6:15 p.m.</u>		Hour <u>12</u> Month <u>14</u> Year <u>57</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway No. 30</u>		20f. CITY, TOWN, OR LOCATION (Near) <u>Brookfield, Linn Missouri</u>	
21. I attended the deceased from Death occurred at <u>DOA 6:19 PM</u> to _____ and last saw her/him alive on _____ m of the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John W. White, D. O.</u>			22b. ADDRESS <u>Brookfield, Missouri</u>		22c. DATE SIGNED <u>12/15/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 15, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>
24. FUNERAL DIRECTOR <u>J. W. Blacklock, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-15-57</u>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson Reg.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 Ronald I Wade

Licensed Embalmer No. 4172

P. O. Address Browning

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.