

FILED DEC 23 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

449986  
STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 142

V. S. 300  
Rev. 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>Marion</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>15 minutes</u>	d. STREET ADDRESS (If outside, give location) <u>4007 Overhill</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Andrew</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>July 2, 1926</u>
9. AGE (In years last birthday) <u>31</u>		FUNDER 1 YEAR Months <u>5</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</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>Reuben C. Fishback</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Moppes</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Yvonne Fishback</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>494-22-5233</u>	17. INFORMANT <u>Mrs. Yvonne 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>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
DUE TO (b) <u>Injuries sustained in two car auto accident.</u>			
DUE TO (c) <u></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 Hour <u>6:15</u> Month, Day, Year <u>12/14/57</u> p.m.			
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. 36</u>	20f. CITY, TOWN, OR LOCATION <u>(Near) Brookfield, Linn, Missouri</u>	
21. I attended the deceased from <u>DOA</u> and last saw <u>her</u> alive on <u></u> Death occurred at <u>6:15 PM</u> on 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, Mo.</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 Dep.</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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DEC 24 1957

DEC 30 1957

OCT 18 1962

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 *Gerald J. Wads* .....

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.