

Health, Welfare & Public Service

FILED JAN 27 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1238

STATE FILE NUMBER

36

Registration District No. 149 Primary Registration District No. 1002 Registrar No. 36

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3821 Warwick</b>		Length of stay in 1b <u>          </u>	d. STREET ADDRESS (If outside, give location) <b>3821 Warwick Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>JANE</b> Last <b>FISHER</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>4,</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-24-1880</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR: Months <u>          </u> Days <u>          </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) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Cass County, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Thomas Brown</b>		13b. MOTHER'S MAIDEN NAME <b>Ann Page</b>	
14. NAME OF HUSBAND OR WIFE <b>Gus W. Fisher</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-24-3195A</b>	
17. INFORMANT <b>Mrs. Minnie Ann Hinrichs</b>		Address <b>K. C. Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Volvular Heart Disease</b>					
20a. ACCIDENT <input 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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1947</u> to <u>1-4-58</u> and last saw her <sup>her</sup> alive on <u>1-3-58</u> Death occurred at <u>4:00</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Esther Winkelman M.D.</b>			22b. ADDRESS <b>7449 Broadway K.C.Mo</b>		22c. DATE SIGNED <b>1-4-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1-6-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY</b>		ADDRESS <b>Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-4-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

*Dr. C. Erwin*

*7449 Broadway*

*7449 Broadway*



**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 *Walter H. Erwin*

Licensed Embalmer No. *4352*  
P. O. Address *H. C. Mc*

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.