

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005496

STATE FILE NUMBER

528

FILED FEB 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 528

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hosp.</u>			Length of stay in lb <u>3 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>4716 Terrace</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>E.</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>58</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>11/10/93</u>		9. AGE (In years last birthday) <u>64</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool Room Foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BENDIX</u>		11. BIRTHPLACE (City and state or country) <u>FAIRFIELD, IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PETER H. FISHER</u>				14. MOTHER'S MAIDEN NAME <u>FLORA MAY PHILLIPS</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>207-056481</u>		17. INFORMANT <u>MRS. BLANCHE C. FISHER</u> Address <u>4716 TERRACE K.C., 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>Multiple abscesses left lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>lobar pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bullous emphysema both lungs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>470 X</u>		
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 _____ Month, Day, Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <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>Sept. 1957</u> , to <u>Jan 30, 1958</u> and last saw ^{him} <u>him</u> alive on <u>Jan 30, 1958</u> (Death occurred at <u>11:30</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Thelma Jones</u> (Degree or title) <u>MD</u>				22b. ADDRESS <u>411 Nichols Rd</u>		22c. DATE SIGNED <u>1-30-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>FEB. 2, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>FAIRFIELD, IOWA</u>			
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u> ADDRESS <u>K.C., MO.</u>			25. DATE RECD. BY LOCAL REG. <u>2-1-58</u>		26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>				

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

T. Reid Jones

Health, Welfare, Public Service
300 1-56
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All

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1-1330

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... *Chester K. Broe*

Licensed Embalmer No. *4*

P. O. Address... *Ke*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.