

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013234
STATE FILE NUMBER

FILED MAY 12 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 205

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Freeburg</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>University Medical Center</u>		Length of stay in lb <u>4 days 5 hours</u>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Bryan</u> Last <u>Fisher</u>			4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>58</u>		
5. SEX <u>Female</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>FEB-11-16</u>		9. AGE (In years last birthday) <u>42</u> IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Osage Co. Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>James Bryan</u>		13b. MOTHER'S MAIDEN NAME <u>Dora Wulpp</u>	
14. NAME OF HUSBAND OR WIFE <u>Paul Fisher</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>—</u>	
17. INFORMANT <u>Hospital Chart</u>		Address <u>Columbia, Missouri</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>Brain Tumor or Abscess</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ 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>355X</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 WRS.</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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>VIENNA</u>		COUNTY _____ STATE _____	
21. I attended the deceased from <u>4-29-58</u> to <u>5-3-58</u> and last saw her alive on <u>5-3-58 at 6th Pm.</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>William G. Dyer Jr. M.D.</u> (Degree or title)		22b. ADDRESS <u>University of Missouri Medical Center</u>	
22c. DATE SIGNED <u>5-3-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>MAY 4, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Victoria Park</u>		23d. LOCATION (City, town, or county) <u>VIENNA</u>		(State) <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>Jack H. Fausch</u>		ADDRESS <u>Lewis Columbia Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 4 1958</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		(Licensed Embalmer's Statement on Reverse Side)			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *John M. Hillis*

Licensed Embalmer No. *4897*

P. O. Address: *Columbus, Mo.*

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.