

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002217

STATE FILE NUMBER

FILED JAN 20 1959

Registration District No. 234 Primary Registration District No. 4349 Registrar's No. 1

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-57

1. PLACE OF DEATH a. COUNTY MORGAN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MORGAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN STOVER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN STOVER 0710 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WALNUT ST.		Length of stay in lb 3 yrs.	d. STREET ADDRESS (If outside, give location) WALNUT ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE FISCHER			4. DATE OF DEATH Month Day Year JAN. 13 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 25 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM		10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (City and state or country) MORGAN County Mo
13a. FATHER'S NAME HENRY FISCHER		13b. MOTHER'S MAIDEN NAME MINNIE TAGMEYER	14. NAME OF HUSBAND OR WIFE PAULINE FISCHER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 490-46-8953	17. INFORMANT Address PAULINE FISCHER STOVER Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Paralysis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Anoxia DUE TO (c) Cerebral Hemorrhage. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes
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.) 331x	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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 15 June 1956 to 18 Jan 1959 and last saw her alive on 13 Jan 1959 Death occurred at 3:15 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Edward A. Koffa D.O.		22b. ADDRESS Stover, Mo	22c. DATE SIGNED 1/15/59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE JAN. 16 1959	23c. NAME OF CEMETERY OR CREMATORY STOVER CEMETERY	23d. LOCATION (City, town, or county) (State) STOVER Mo.
24. FUNERAL DIRECTOR ADDRESS J. L. Swinson Stover Mo		25. DATE RECD. BY LOCAL REG. Jan. 13 1959	26. REGISTRAR'S SIGNATURE Wm L. Ripberger

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. L. Swinson*

Licensed Embalmer No. *4073*
P. O. Address *Stover, 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.