

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-020810

 DEED
 Registration District No. 93 Primary Registration District No. _____ Registrar's No. 59-53 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo.</u>		Length of stay in 1b <u>1:15 hr</u>		c. CITY OR TOWN <u>Greenfield Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1 Mi South</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Sallie</u> Middle <u>Vincent</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24 1868</u>		9. AGE (last birthday) <u>91</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>					
13a. FATHER'S NAME <u>M. P. Vincent</u>				13b. MOTHER'S MAIDEN NAME <u>unknown</u>				14. NAME OF HUSBAND OR WIFE <u>John R 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>none</u>		17. INFORMANT Address <u>Lasca E Pillow Greenfield 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>Congestive Heart failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Occlusion</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) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from <u>7-2-59</u> to <u>7-3-59</u> and last saw ^{her} him alive on <u>7-3-59</u> . Death occurred at <u>2:20A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Elmer W. Taylor M.D.</u>						22b. ADDRESS <u>807 Main St Lockwood Mo</u>			22c. DATE SIGNED <u>7/3/59</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 3 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Dyer, Tenn. Gipson Co.</u>							
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7/3/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canade</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W.R. Allison

Licensed Embalmer No. 4407

P. O. Address Greenville

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