

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028283

FILED VS AUG 31 1959 042

862

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

INDEXED

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marion Twp.	Length of stay in 1b 70 Yrs	c. CITY OR TOWN Easton	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RFD # 1 Easton, Mo.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD # 1
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First PETER Middle J. Last FISHER			4. DATE OF DEATH Month August Day 21 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1864	9. AGE (last birthday) 95	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (S) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (City and state or country) Clinton, County Mo.	12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME Michael Fisher	13b. MOTHER'S MAIDEN NAME Regina Vaeth	14. NAME OF HUSBAND OR WIFE Elizabeth
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. None	17. INFORMANT Beatrice Fisher R. 1 Easton, 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) Coronary thrombosis, probable		INTERVAL BETWEEN ONSET AND DEATH about 6 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic heart disease		unknown
	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 type="checkbox"/> No <input type="checkbox"/> Unknown	

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.)
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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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Easton, Mo.	COUNTY _____ STATE _____
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21. I attended the deceased from 2/18/59 to 8/21/59 and last saw him alive on 8/21/59 Death occurred at 3:00 A m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Wm Redmond MD (Degree or title)	22b. ADDRESS St Joseph, Mo	22c. DATE SIGNED 8/21/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery
23d. LOCATION (City, town, or county) Easton, Mo.		(State) _____

24. FUNERAL DIRECTOR H.O. Hidenfager & Son	ADDRESS St Joseph Mo.	25. DATE RECD. BY LOCAL REG. Aug. 22, 1959	26. REGISTRAR'S SIGNATURE Wm. Clark Goodall
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DOCUMENT

Wm Redmond, MD, Medical Certification

BY AFFIDAVIT OF

VS JUN 22 1966 SA

Dr Redman

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 *Robert H. Apple*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.