

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000504

FILED VS FEB 14 1961 389

STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5165 Registrar's No. 1

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Callaway</u>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Guthrie TWP</u>		c. CITY OR TOWN <u>Guthrie MO</u>		d. STREET ADDRESS (if outside, give location) <u>Rt. 2 New Bloomfield</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Guthrie TWP</u>		Length of stay in lb <u>8 yrs.</u>		c. CITY OR TOWN <u>Guthrie 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>1 mi West Guthrie MO</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willis Wheeler Fisher</u>			4. DATE OF DEATH Month Day Year <u>Feb 6 1961</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>Jan 26-94</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Farm</u>		11. BIRTHPLACE (City and state or country) <u>Fulton Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Chas. Henry Fisher</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Jane Boggs</u>		14. NAME OF HUSBAND OR WIFE <u>Helen 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>NO</u>		17. INFORMANT Address <u>Rt 2 Mrs Willis Fisher New Bloomfield</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>General Arterio Sclerosis</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)					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		
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 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>Aug 7 1960</u> , to <u>Feb 6 1961</u> and last saw him alive on <u>Feb 5 - 1961</u> Death occurred at <u>3 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>E. M. D. Rusk M.D.</u>				22b. ADDRESS <u>New Bloomfield Mo</u>		22c. DATE SIGNED <u>2/17/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DRY Fork Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>West Guthrie MO</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Chaypool Service New Bloomfield</u>			25. DATE RECD. BY LOCAL REG. <u>2-6-61</u>		26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u>		

MS FEB 14 1968

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 Rehag Clayton

Licensed Embalmer No. 4412

P. O. Address New Bloomfield 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.