

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-000335

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

99

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri		Length of stay in 1b Adm. 8-30-61	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2		c. CITY OR TOWN Easton, Mo.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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 Middle Last Elizabeth Fisher			4. DATE OF DEATH Month Day Year Jan. 29 1962			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-12-1872	9. AGE (last birthday) 89	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) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME William Fisher		13b. MOTHER'S MAIDEN NAME Mary Louise Weidmier		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, St. Joseph, Mo.		

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) Arteriosclerotic Heart Disease		
DUE TO (b) Generalized Arteriosclerosis		
DUE TO (c) Pulmonary Tuberculosis bilateral		
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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
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 Jan. 29, 1962 to Jan. 29, '62 and last saw her/him alive on Jan. 29, 1962  
Death occurred at 5:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James Thomas MD		22b. ADDRESS Sub Nap 107 Rt. No. 770	22c. DATE SIGNED 1/29/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 31, 1962	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City, town, or county) (State) Hurlingen, Mo.

24. FUNERAL DIRECTOR H.O. Sidenfaden & Son St. Joseph Mo PT4	ADDRESS	25. DATE RECD. BY LOCAL REG. Jan. 29, 1962	26. REGISTRAR'S SIGNATURE Mrs. Charles Goodell
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

F. Thomas, M.D. Medical Certification

**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 \_\_\_\_\_

*Robert H. Gayer*

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.