

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N.B. Every year or anniversary should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33892
Registrar's No. 8430

Registration District No. 1003 Primary Registration District No. _____

1. PLACE OF DEATH: 2
 (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3137 Iowa Ave.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St. Louis 24
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3137 Iowa Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mary E. Fischer 260
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife Abton J. 6. (c) Age of husband or wife if alive 66 years
 7. Birth date of deceased March 22 1877
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day hr. min.
	62	6	8	

9. Birthplace St. Louis, Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER
 { 12. Name Anton Schmid 6
 13. Birthplace Germany (State or foreign country)
 14. Maiden name Elizabeth Iaber
 15. Birthplace Germany (State or foreign country)

16. (a) Informant's own signature Anton J. Fischer
 (b) Address 3137 Iowa Ave

17. (a) Burial (b) Date thereof Oct. 3, 1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation New SS. Peter & Paul

18. (a) Signature of funeral director J. H. Becklund
 (b) Address 21930 Gravois Ave.

19. (a) _____ (b) J. H. Becklund
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30th
 year 1939 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept 10 29 1939, to Sept 30 1939
 that I last saw him alive on Sept 30 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
coronary arteriosclerosis
 Duration unknown

Due to _____
 Due to of liver
Cirrhosis (Partial) 3-1-39
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: none
 Of operations _____
 Of autopsy none
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following: no
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? _____ (Specify type of place)
 (e) Means of injury fall

28. Signature W. H. Schneider (M. D. or other) MD
 Address 3218 S Grand Date signed 9-30-39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Herman A. Gebken*

Licensed Embalmer No. *2120*
2842 Meramec St.
P. O. Address..... *St. Louis, 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 this body is not embalmed, above space should be left blank.