

Registration District No. 2367

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution City Hospital
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

8. (a) PRINT FULL NAME Thomas Fisher

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

8. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE Years Months Days If less than one day
Adol 52

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Jengulung

(b) Address 6051 Delshire

17. (a) _____ (b) Date thereof 12-15-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of informant W. Richter

(b) Address 3800 Rutger
DEC 28 1939

19. (a) _____ (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis 24
(If outside city or town limits, write "RURAL.")
(d) Street No. 3700 S. Waver
(If rural, give location) Shack # 169
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 6
year 1939 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Subdural Haemorrhage of Brain

Due to Haematoma of Left Side of scalp

Due to _____

Other conditions (Include pregnancy within _____ months of death) Varicose veins of Leg

Major findings: Of operations _____

None, Race, Cause of Marasmus could not be ascertained

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Open Verdict

(b) Date of occurrence Unknown

(c) Where did injury occur? Unknown
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Unknown

While at work? _____ (Specify type of place)

23. Signature Joseph M. Sullivan (M. D. or other) _____

Address Deputy Date signed _____

Duration

PHYSICIAN

Underline the cause of death which should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.