

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(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:
3630 Indiana 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 50 years
years, months or days)

3. (a) PRINT FULL NAME Albert J. O. Fischer 260

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 Widower

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

7. Birth date of deceased May 19, 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>10</u>	<u>15</u>	hr. _____ min.

9. Birthplace: Collinsville Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name John Fischer

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Armin Haerber

(b) Address 3630a Indiana

17. (a) Burial (b) Date thereof 4/6/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Our Redeemer

18. (a) Signature of funeral director Wacker-Heldens

(b) Address 2331 S. Broadway

19. (a) APR 5 1940 (b) J. J. Bieder
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 34
(If outside city or town limits, write "RURAL")
 (d) Street No. 3630 Indiana Ave.
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 4
 year 1940 hour 6 minute 25 a. m.

21. I hereby certify that I attended the deceased from February 25th, 1936 to April 4th, 1940
 that I last saw him alive on April 4th, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Chronic Endocarditis - 12 years
 Due to Atherosclerosis - 14 years
Anterior Sclerosis -

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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

(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? _____

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

23. Signature William Baron (M. D. or other) _____
 Address 3601 N. 5th St. Jefferson Date signed 4/4/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WHILE FILLING IN 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..... *Frank J. Land Jr.*
Licensed Embalmer No..... *2645*
P. O. Address..... *Howe*

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.