

FILED FEB 16 1943 **318**

Registration District No.

Primary Registration District No. **1003**

Registrar's No. **1173**

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Little Sisters of Poor 5
3400 N. Grand - 6 years
(d) Length of stay: In hospital or institution (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Joseph Fischang

3. (b) If veteran, name war 770

3. (c) Social Security No. 770

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widower 2
6. (b) Name of husband or wife Christine Fischang 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 4 1866
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 0 If less than one day hr. min.

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

10. Usual occupation Retired Beer Bottler

11. Industry or business

12. Name Unknown Fischang

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

14. Maiden name Unknown

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

16. (a) Informant Frank Fischang
(b) Address 2843 Missouri Av

17. (a) Burial (b) Date thereof 2-8-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marcellus

18. (a) Signature of funeral director W. J. ...
(b) Address 2929 S. Jefferson Av

19. (a) FEB 5 1943 J. J. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3400 S. Grand Bld.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4
year 1943 hour 10 minute 30p. M.

21. I hereby certify that I attended the deceased from 1-19-43 to 2-7-43
that I last saw him alive on 2-4-43 and that death occurred on the date and hour stated above.

Immediate cause of death acute myocarditis from
Hypertension, senility.
Due to Hypertension, senility.

Duration 2 days
Due to Hypertension, senility. several years.

Other conditions (Include pregnancy within 3 months of death) 175

Major findings: Of operations 18
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) (e) Means of injury

23. Signature Eugene H. Edelle (M. D. or other) M.D.
Address 3019 S. Jefferson Ave. Date signed 2-5-43

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

MOTHER FATHER

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 Gustav W Dietrich

Licensed Embalmer No. 4329

P. O. Address 2929 S Jefferson

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, fact should be so stated above.