

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 16 1949

State File No. 21004

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4967

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) (10) 3513 N. Spring Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3513 N. Spring Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) Emil b. (Middle) c. (Last) Fiebig			4. DATE OF DEATH (Month) (Day) (Year) 6 6 1949			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 30- 1876	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME August Fiebig	13b. MOTHER'S MAIDEN NAME Augusta Vollen	14. NAME OF HUSBAND OR WIFE Jennie Fiebig
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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. 494-01-7605	17. INFORMANT'S SIGNATURE OR NAME Jennie Fiebig	ADDRESS 3513 N. Spring Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Chronic myocarditis		1 year
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b)		
		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. W. Harris M.D. II	23b. ADDRESS 3505 N. Grand	23c. DATE SIGNED 6-7-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-9-1949	24c. NAME OF CEMETERY OR CREMATORY National Cemetery	24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo
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DATE REC'D BY LOCAL REG. JUN 7 1949	REGISTRAR'S SIGNATURE T. B. Loscher M.S.	25. FUNERAL DIRECTOR'S SIGNATURE H. Leidner U.	ADDRESS 2223 St. Louis Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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

OK-165-4

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
Student Embalmer

Signed John P. Buchholz
Licensed Embalmer No. 1674
P. O. Address 2223 St. Louis

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.

Dr. W. W. Fairis