

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24785
6500

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Oregon			
b. CITY (If outside corporate limits, write RURAL and give town) St Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) Alton		3. _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Anthony Hospital				d. STREET ADDRESS (If rural, give location) NR.			
3. NAME OF DECEASED (Type or Print) a. (First) Carolyn b. (Middle) _____ c. (Last) Fisher			4. DATE OF DEATH (Month) (Day) (Year) 7-26-1949				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH 9-14-1933	
9. AGE (In years last birthday) 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Norman Fisher		13b. MOTHER'S MAIDEN NAME Isol Holden		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Norman Fisher ADDRESS Alton, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Paralysis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Poliomyelitis, acute DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION 7-24-49		19b. MAJOR FINDING(S) OF OPERATION Tracheostomy				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Alton Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 0800			
22. I hereby certify that I attended the deceased from 7-24, 1949 to 7-25, 1949 , that I last saw the deceased alive on 7-25, 1949 and that death occurred at 11:20 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Joseph E. Carney				23b. ADDRESS 706 Olive St		23c. DATE SIGNED 7-26-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-26-49		24c. NAME OF CEMETERY OR CREMATORY Alton		24d. LOCATION (City, town, or county) (State) Mo.	
DATE REC'D BY LOCAL REG. Aug 22 1949		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.			

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

1051

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 Ronald Dyakurke

Licensed Embalmer No. 3917

P. O. Address. Atkins 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, fact should be so stated above.