No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24559

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5742

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. John's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 14 St. Louis 2149
d. STREET ADDRESS (If rural, give location): 5659 Potomac Street 0

3. NAME OF DECEASED (Type or Print)
a. (First): Augusta
b. (Middle):
c. (Last): Fischer

4. DATE OF DEATH (Month) (Day) (Year): June 23 1951

5. SEX: Female 1
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: 5/4/1901
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months 1, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: X
11. BIRTHPLACE (State or foreign country): Herne, Westphalia, Germany 4
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: August Kieser
13b. MOTHER'S MAIDEN NAME: Elizabeth ?
14. NAME OF HUSBAND OR WIFE: William Fischer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: X
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Wm. Fischer 5659 Potomac St.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): General Arteriosclerosis — 1 year.
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 ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 332X

22. *I hereby certify that I attended the deceased from* June 15, 1951, *to* June 23, 1951, *that I last saw the deceased alive on* June 23, 1951, *and that death occurred at* 9:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Martin W. Davis M. D.
23b. ADDRESS: Humbolt Bldg.
23c. DATE SIGNED: JE-4980

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 1
24b. DATE: 6/27/51
24c. NAME OF CEMETERY OR CREMATORY: Oak Grove Chapel
24d. LOCATION (City, town, or county) (State): St Louis, Mo

DATE REC'D BY LOCAL REG.: JUN 26 1951
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ambruster Mortuary, 6633 Clayton Rd.

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed R J Ambrosia

Signed.....
Student Embalmer

Licensed Embalmer No. 1994

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.