

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29950

FILED AUG 31 1953

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State File No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <u>7628</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3903 OLIVE</u>				e. STREET ADDRESS (If rural, give location) <u>24 3145 Osage St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALICE</u>		b. (Middle) <u>MARIE</u>		c. (Last) <u>FISCHER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 3, 1953</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>March 30, 1947</u>	
9. AGE (In years last birthday) <u>6</u>		if UNDER 1 YEAR Months <u>4</u>		if UNDER 2 HRS. Days <u>3</u>		Hours <u>0</u> Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Leo A. Fischer</u>		13b. MOTHER'S MAIDEN NAME <u>Helen Antonio</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Leo A. Fischer 3145 Osage St.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute lobar Pneumonia</u> ANTECEDENT CAUSES Morbid 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. <u>Cerebral Palsy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) <u>490X</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>7/17</u> , 19 <u>53</u> , to <u>8/13</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>7/17</u> , 19 <u>53</u> , and that death occurred at <u>2:10 p.m.</u> , from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) <u>Donald J. Mehner M.D.</u>				23b. ADDRESS <u>8903 Olive St</u>		23c. DATE SIGNED <u>8/3/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/3/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>AUG 4 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons 2630 Gravois.</u>			

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

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.....
Signature of Student Embalmer

Signed..... *Robert F. Gibken*

Licensed Embalmer No. *4144*

P. O. Address *2630 Gravo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.