

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

7216

State File No. \_\_\_\_\_

No. 300  
10-48

BIRTH NO. FILED FEB 18 1954 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 548 Registrar's No. 303

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Webster Groves</b>		c. LENGTH OF STAY (In this place) <b>few hours</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Glenwood Sanitarium</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Lemay, Missouri</b>	
		d. STREET ADDRESS (If rural, give location) <b>778 Reed Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ELIZABETH</b> b. (Middle) <b>M.</b> c. (Last) <b>FISCHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 1 1954</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 24, 1886</b>	9. AGE (In years last birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home - Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>George Preisinger-Bock</b>	13b. MOTHER'S MAIDEN NAME <b>? Wolf</b>	14. NAME OF HUSBAND OR WIFE <b>Philip Fischer</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mr. Philip J. Fischer, 778 Reed Ave., Lemay</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Wasting from a malignant tumor of the throat, with chronic heart disease and hypertension, which was hastened by self-ingested dose of tincture of iodine.</b>		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>97184</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Suicide</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Lemay - St. Louis Mo.</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>2/31/54</b> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Self-ingested dose of tincture of iodine.</b>
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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 **2:00 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Arnold J. Willman, Coroner</b>	23b. ADDRESS <b>Clayton, Mo.</b>	23c. DATE SIGNED <b>2/4/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>2-4-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>2-3-54</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Beidervieden F.H. Inc., 1936 St. Louis Ave.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

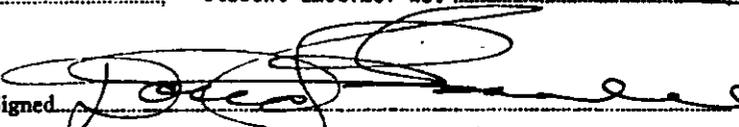
STATEMENT BY LICENSED EMBALMER

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 .....  
Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 4520

P. O. Address H. J. Fairman

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.