

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24447

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6365**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST. CLAIR</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>ST. LOUIS</b>		c. LENGTH OF STAY (If in this place) <b>5 DAYS</b>	c. CITY OR TOWN <b>E. St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>424 South 6 St.</b>		3120 8	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>ESTO</b>	b. (Middle) <b>P.</b>	c. (Last) <b>DEISCHER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 11 1954</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-12-1901</b>	9. AGE (In years last birthday) <b>53</b>	10. UNDER 1 YEAR Months <b>4</b> Days <b>0</b> Hours <b>0</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAIL HANDLER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>MADE, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Michael Deischer</b>	13b. MOTHER'S MAIDEN NAME <b>MARY Howey</b>	14. NAME OF HUSBAND OR WIFE <b>VIRGINIA Deischer</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>117-03-8931</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Virginia Deischer</b> ADDRESS <b>E. St. Louis</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>Metastatic parietal-lobe brain tumor &amp; hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Pancreatic primary carcinoma</b>		
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 checked="" 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)
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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 <b>157X</b>
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22. I hereby certify that I attended the deceased from **7-6-54**, 19\_\_\_, to **7-11-54**, 19\_\_\_, that I last saw the deceased alive on **7-11-54**, 19\_\_\_, and that death occurred at **10:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph M. Hunter Jr. M.D.</b> (Degree or title)	23b. ADDRESS <b>1515 Lafayette Avenue</b>	23c. DATE SIGNED <b>7-12-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>7-13-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>E. St. Louis ILL</b>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <b>JUL 13 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Robins</b> ADDRESS <b>E. St. Louis Ill</b>
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WRITE PLAINLY—USING UNFADEING 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 *Frank Proloff*.....

Licensed Embalmer No. *435*.....

P. O. Address *Shelby*.....

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.