

FILED AUG 6 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24528  
State File No. ....  
6510  
Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MO</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS MO</b>		c. LENGTH OF STAY (In this place) <b>33 yr</b>		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4325 MORGANFORD RD</b>				e. STREET ADDRESS (If rural, give location) <b>15 4325 MORGANFORD RD</b>					
3. NAME OF DECEASED (Type or Print) <b>CATHERINE CAROLINE FISCHER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7 - 15 - 1954</b>						
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>10 - 13 - 1874</b>		9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 12 HRS. Hours Min.		
10a. USUAL OCCUPATION* (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>ADAM GREENWALD</b>		13b. MOTHER'S MAIDEN NAME <b>CAROLINE ZELLER</b>		14. NAME OF HUSBAND OR WIFE <b>JACOB FISCHER</b>					
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>JACOB FISCHER 4325 MORGANFORD</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hrs</b>			
				ANTECEDENT CAUSES		DUE TO (b) <b>Hypertensive Heart disease</b>		12 years	
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death. <b>Ca of rectum = metastatic</b>		3-4 yrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4201H</b>					
22. I hereby certify that I attended the deceased from <b>March 1</b> , 19 <b>46</b> , to <b>July 15</b> <sup>th</sup> , 19 <b>54</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>54</b> , and that death occurred at <b>6 1</b> m., from the causes and on the date stated above.									
23a. SIGNATURES (Degree or title) <b>Paul Young, M.D.</b>				23b. ADDRESS <b>3624 Russell</b>		23c. DATE SIGNED <b>7-30-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>7-17-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. PAUL CHURCH YARD</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY MO</b>			
DATE REC'D BY LOCAL REG. <b>JUL 16 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Muehl</b>		ADDRESS <b>5930 SOUTHWEST</b>			

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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.....  
Licensed Embalmer No.....  
P. O. Address.....

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.