

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 58 yrs.		e. STREET ADDRESS (If rural, give location) 5 5927 DeGiverville 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 5927 DeGiverville			

3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) MARTHA FISCHER		4. DATE OF DEATH (Month) (Day) (Year) Nov 29 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.	8. DATE OF BIRTH June 29, 1875
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
11. BIRTHPLACE (City and State or Foreign Country) Germany 4		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Salo Daust	13b. MOTHER'S MAIDEN NAME ---	14. NAME OF HUSBAND OR WIFE Henry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry Fischer 5927 DeGiverville

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 2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Art. Sclerotic Heart Disease</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Art. Sclerosis</i> 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 <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) D	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4200
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 11/24, 1954, to 11/29, 1954, that I last saw the deceased alive on 11/27, 1954, and that death occurred at 10:22 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Charles E. Strickland M.D.</i>	23b. ADDRESS 539 N. Grand	23c. DATE SIGNED 1/29/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 12/2/54	24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai
24d. LOCATION (City, town, or county) (State) St. Louis County		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson
DATE REC'D BY LOCAL REG. NOV 30 1954	REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

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 *James J. Anderson*.....

Licensed Embalmer No. *488*.....

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.