

Health,  
& Welfare  
Public  
Service

FILED SEP 20 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32868  
STATE FILE NUMBER

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 92

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Perry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Perryville</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Perry Co Mem. Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>5523 Nottingham</u>	
Length of stay in 1b <u>4 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Fiehler</u>			4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1957</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4 1884</u>	9. AGE (In years last birthday) <u>73</u>	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retire Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Perry County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Benjamin Fiehler</u>	13b. MOTHER'S MAIDEN NAME <u>Bertha Doberenz</u>	14. NAME OF HUSBAND OR WIFE <u>Anna Fiehler</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>488-42-0869</u>	17. INFORMANT <u>Anna Fiehler</u>	Address <u>St. Louis Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3d.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertensive cerebral arteriosclerosis</u>	<u>4yr.</u>
	DUE TO (c) <u>4200</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>8-24-57</u> to <u>8-27-57</u> and last saw him alive on <u>8-27-57</u> Death occurred at <u>130A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. F. Fairchild, M.D.</u> (Doctor or title)	22b. ADDRESS <u>Perryville, Mo.</u>	22c. DATE SIGNED <u>8-30-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 29, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	23d. LOCATION (City, town, or county) (State) <u>Frohna Missouri</u>
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24. FUNERAL DIRECTOR <u>Youngs Sons Perryville Mo</u>	ADDRESS <u>9-6-57</u>	25. DATE RECD. BY LOCAL REG. <u>9-6-57</u>	26. REGISTRAR'S SIGNATURE <u>Joe J. Zolner</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

59

APR 23 1958

MS  
FEB 1 1950

### 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 *Wallace Young* .....

Licensed Embalmer No. *4027* .....

P. O. Address *Perryville* .....

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.