

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038479

ED VS NOV 16 1959 #317

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 2957 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Frontenac		Length of stay in 1b 2 mos.		c. CITY OR TOWN Lincoln		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 104 Frontenac Forest			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3405 N. Street			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANK FISER				4. DATE OF DEATH Month Day Year November 7, 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Apr. 4, 1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months 7 Days 3	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Standard Market		11. BIRTHPLACE (City and state or country) Austria		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME John Fiser			13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mary Kovar		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 506-07-2354		17. INFORMANT Address Gilbert Fiser, 104 Frontenac Forest			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach with metastases						INTERVAL BETWEEN ONSET AND DEATH 4 MO. MINIMUM	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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
21. I attended the deceased from <u>Sept 59</u> to <u>NOV. 7 59</u> and last saw him alive on <u>Nov. 5, 1959</u> Death occurred at <u>11-7-59</u> <u>755 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE John C Doubek Jr MD (Degree, or title)				22b. ADDRESS 2767 Francis		22c. DATE SIGNED 11-7-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Nov. 7, 1959	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Lincoln, Nebraska		
24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd. ADDRESS			25. DATE RECD. BY LOCAL REG. 11-6-59		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1900
JAN 26 1900

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 Fred J. Hammer

Licensed Embalmer No. 4788

P. O. Address St. Louis Mo.

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.