

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**

**59-041823**

**FILED VS. NOV 16 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2,9225** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>5 days</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>750 Leland</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>EDWARD</b> Middle <b>FRED</b> Last <b>FISCHER</b>			<b>4. DATE OF DEATH</b> Month <b>Oct.</b> Day <b>7,</b> Year <b>1959</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/3/81</b>	<b>9. AGE (last birthday)</b> <b>77</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Druggist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retail Drug Store</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo.</b>	
<b>13a. FATHER'S NAME</b> <b>Christian F. Fischer</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Charlotte Tepe</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ethel</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>494-05-5001</b>		<b>17. INFORMANT</b> Address <b>Ethel Fischer 750 Leland</b>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Coronary arteriosclerosis - Angina Pectoris</b> DUE TO (c) <b>420.1</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b> <b>2 years.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from **Feb. 1937** to **Oct 6, 1959** and last saw him live on **Oct. 6/1959**  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>Alfred Goldsman M.D.</b>	<b>22b. ADDRESS</b> <b>634 N. Ogden</b>	<b>22c. DATE SIGNED</b> <b>10/15/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Rem.</b>	<b>23b. DATE</b> <b>10/8/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Sinai</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Berger Memorial 4715 Mc'hersob</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>OCT 8 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Loard Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*207E*

**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 *Lawrence J. King*

Licensed Embalmer No. 3988

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.