

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035254

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2412

FILED SEP 19 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>S</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in 1b <u>20 Hrs.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5445 Thrush</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Fieser</u> Last			4. DATE OF DEATH Month <u>Aug.</u> Day <u>26</u> Year <u>1961</u>		
5. SEX <u>Female</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>2/15/1892</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>        </u> Days <u>        </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Given</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Oster</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Fieser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			17. INFORMANT Address <u>Charles Fieser 5445 Thrush Ave.</u>		

18. CAUSE OF DEATH (Enter only one cause per line (1), (2), (3), (4), (5). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Supraventricular Tachycardia &amp; Shock</u>		<u>20 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Rheumatic Heart Disease</u>	<u>30+ yrs.</u>
	DUE TO (c) <u>Mitral Stenosis &amp; Insufficiency</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rt. hemiparesis due to Emboli 410x</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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 <u>        </u> Month, Day, Year <u>        </u> a.m. <u>        </u> p.m. <u>        </u>				

20d. INJURY OCCURRED 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
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21: I attended the deceased from June 1960 to 8/26/61 and last saw her her alive on 8/26/61  
Death occurred at 3:00 PM 8/26 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Richard J. Danner MD</u> (Degree or title)	22b. ADDRESS <u>9313 Manchester</u>	22c. DATE SIGNED <u>8/29/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/29/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Ann, Mo.</u>
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24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-28-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Am

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.