

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-038541
STATE FILE NUMBER

AMENDED

Registered District No. 8-196318 Primary Registration District No. 1003 Registrar's No. 9942

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MO</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LUTHERAN Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>1926 TELEGRAPH</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE FISCHER</u>			4. DATE OF DEATH Month Day Year <u>OCT. 25 1961</u>
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>MAR. 27 1896</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MILLWRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NATIONAL LEAD</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>MAX FISCHER</u>	
13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE FISCHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT <u>MINNIE FISCHER</u> Address <u>1926 TELEGRAPH</u>
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>Carcinomatosis - massive</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
DUE TO (b) <u>—</u>			
DUE TO (c) <u>199.2</u>			
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
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>6-1-61</u> to <u>10/25/61</u> and last saw him alive on <u>10/25/61</u> Death occurred at <u>10:05 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert H. Cason, M.D.</u> (Degree or title)		22b. ADDRESS <u>4401 HAMPTON AVE</u>	22c. DATE SIGNED <u>10/26/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT. 30 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO, MO</u>
24. MUNICIPAL DIRECTOR <u>Thomas Kuttis</u> ADDRESS <u>2906 Grand</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 27 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	

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 *Carolyn H. [Signature]*

Licensed Embalmer No. 4861

P. O. Address Salaya 5, [unclear]

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.