

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028625

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2043** STATE FILE NUMBER

**FILED JUL 31 1962**

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	c. CITY OR TOWN		Inside Limits
		St. Louis			Mo.			St. Louis		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits	d. STREET ADDRESS (if outside, give location)			Reside on Farm		
7117 A Michigan				Yes <input type="checkbox"/> No <input type="checkbox"/>	7117 A Michigan			Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year
Minnie					J. Fischer	July 16				1962
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR			
Female	White		8/26/1888	73	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
House Wife			At Home		Columbia Mo.		USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
John Volkert				Augusta Heilenstedt			Albert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address				
No.						Marion Wallace 7117a Michigan				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>										4 DAYS
DUE TO (b) <u>1. ARTERIO SCLEROTIC HEART DISEASE &amp; Congestive Heart Failure</u>										5 YEARS.
DUE TO (c) <u>2. CEREBRAL ARTERIO SCLEROTIC CHANGES.</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.
<u>HEMIPLEGIA DUE TO PREVIOUS Cerebral Vas. Accident</u>										<input type="checkbox"/> Yes <input checked="" 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, 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		1959		to July 16, 1962		and last saw her		7/14/62		
Death occurred at		4:15 P		m		on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title)				22b. ADDRESS			22c. DATE SIGNED			
Charles B. Ladd M.D.				3438 S. GRAND BLVD.			7/17/62			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		STATE		
Removal		7/19/1962		Memorial Park		St. Louis Co.		Mo.		
24. FUNERAL DIRECTOR ADDRESS				25. DATE REGD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
JOS. P. FENDLER JR. FUNERAL HOME				JUL 18 1962		Kearl Smith M.D.				

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

1 VS 300 Rev. 4/59

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DOCUMENT

MEDICAL CERTIFICATION

Dr. J. L. Brown  
34 38 J. Brown

**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 W. E. Morris

Licensed Embalmer No. 3360

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.