

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013258

3018

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

318 Primary Registration District No. 1003 Registrar's No. 3018

FILED MAR 21 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Olivette
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 32 Crabapple Ct.
3. NAME OF DECEASED (Type or print)		First Minnie Middle Fischer Last	4. DATE OF DEATH Month March Day 13 Year 1963
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/24/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (last birthday) 85
11a. BIRTHPLACE (City and state or country) Cedar Rapids, Iowa		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME George Engelmann		13b. MOTHER'S MAIDEN NAME Augusta Junker	
14. NAME OF HUSBAND OR WIFE Herman A. Fischer		17. INFORMANT Address Mrs. Clyde Connell, Jr., 32 Crabapple Ct.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Address Mrs. Clyde Connell, Jr., 32 Crabapple Ct.	
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) vascular disease with decompensation			21 days
DUE TO (b) Generalized Arteriosclerosis			3 years
DUE TO (c) 442x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriolar-nephrosclerosis - 2 weeks			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
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 3-29-50 to 3-13-63 and last saw her/him alive on 3-13-63 A. M. Death occurred at 4 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John W. Rath, M.D.</i> (Degree or title)		22b. ADDRESS 823 Mo. Theatre Bldg.	22c. DATE SIGNED 3/14/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/16/63	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR Harry A. Kraeger, 24 Chapel Hill		25. DATE RECD. BY LOCAL REG. MAR 14 1963	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>

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 Harvey Kahl

Licensed Embalmer No. 4596

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.