

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

**PLACE OF DEATH**

County.....

Township.....  
or  
Village.....  
or  
City St. Louis (NO. 7329 Virginia or St. 17 Ward)

Registration District No. 791  
Primary Registration District No. 1003

File No. 29004  
Registered No. 7682

[If death occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME**

John G. Fischer

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married  
(Write the word)

DATE OF BIRTH Feb 5<sup>th</sup>, 1888  
(Month) (Day) (Year)

AGE 67 yrs. 7 mos. 5 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed (or employer) 121 92<sup>th</sup>

BIRTHPLACE (City or town, State or foreign country) Germany

PARENTS  
NAME OF FATHER John C. B. Fischer  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
MAIDEN NAME OF MOTHER Anna Kamm  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Albert Fischer  
(ADDRESS) 7329 Virginia Ave

Filed SEP 22 1915 Maub Starkloff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Sept 10<sup>th</sup>, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 7<sup>th</sup>, 1915, to Sept 10<sup>th</sup>, 1915, that I last saw him alive on Sept 10<sup>th</sup>, 1915, and that death occurred, on the date stated above, at 6:30 m. The CAUSE OF DEATH\* was as follows:

Myocardial Degeneration  
Chronic Tuberculosis Nephritis  
(Duration) 2 yrs. 3 mos. 3 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.  
(Signed) Co. Stone M. D.  
9/12 1915 (Address) 1505 W. Jefferson

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL St. Hope DATE OF BURIAL Sept 13<sup>th</sup>, 1915

UNDERTAKER Simpson & Co ADDRESS 6473 Michigan

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of

..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

PLACE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

County \_\_\_\_\_

Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City St. Louis

Registration District No. 791 File No. \_\_\_\_\_  
Primary Registration District No. 1003 Registered No. 7682  
(No. 7329 Virginia Ave St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME

John G. Fischer

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED  
(Write the word)

DATE OF BIRTH Feb 5th 1850  
(Month) (Day) (Year)

AGE 65 yrs. 7 mos. 15 ds. If LESS than 1 day, hrs. or min.

OCCUPATION (a) Trade, profession, or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Germany

PARENTS  
NAME OF FATHER John G. Fischer  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany  
MAIDEN NAME OF MOTHER Amelia Kaim  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Albert Fischer  
(ADDRESS) 7329 Virginia Ave

Filed 10-3 1951 A. H. Prud'homme REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 10th 1951  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw h\_\_\_\_ live on \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m. The CAUSE OF DEATH\* was as follows: Suppl.

Satisfactory Information Supplier  
Satisfactory Information Supplier  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) \_\_\_\_\_ M. D.  
(Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death: yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State: yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death?  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 191\_\_\_\_  
UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

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use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia, Anaemia*" (merely symptomatic), "*Atrophy, Collapse, Coma, Convulsions, Debility*" ("Congenital," "Senile," etc.), "*Dropsy, Exhaustion, Heart failure, Haemorrhage, Inanition, Marasmus, Old age, Shock, Uraemia, Weakness, etc.*, when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia, PUERPERAL peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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