WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St. Louis Mo. (NO. Sanitarium St.; W Ward)

Registration District No. 791 File No. 30677

Primary Registration District No. 1003 Registered No. 8578

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

2 FULL NAME John Jacob Fischer

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: June (Month) 1 (Day) 1857 (Year)

7 AGE: 61 yrs. 3 mos. 11 ds. If LESS than 1 day, ..... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Chef
(b) General nature of industry business, or establishment in which employed (or employer): City Sanitarium

9 BIRTHPLACE (City or town, State or foreign country): Pennsylvania

PARENTS

10 NAME OF FATHER: John Jacob Fischer

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

12 MAIDEN NAME OF MOTHER: Anna Herman

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Vickrey

(Address) St. Louis Sanit.

15 Filed [illegible] 13 [illegible], 191[illegible] Max C Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: September (Month) 10 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 1, 1918, to September 11, 1918, that I last saw him alive on September 10, 1918, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

III-B

40

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A C Vickrey M. D.

September 11, 1918 (Address) 5400 Arsenal

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 6 yrs. 2 mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 3251 Indiana Av.

19 PLACE OF BURIAL OR REMOVAL: New Pickers

DATE OF BURIAL: Sept 13, 1918

20 UNDERTAKER: Math Hermann 4141 W Ploussant Ave

ADDRESS

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ..... St.; ..... Ward)

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

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

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

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

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

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., .....
Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

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

18 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 .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191..... |
|---|---|
| 20 UNDERTAKER | ADDRESS |

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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