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

Do not use this space.

2657

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 107

City St Louis Mo (No. 5165 Cabannee Ave St. ..... Ward)

File No. .....

Registered No. 219

2. FULL NAME David Fischer

(a) Residence. No. 4130 Lee Place St., 10 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 21st 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	59	1	14	

8. OCCUPATION OF DECEASED 1630

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Forest Park

(c) Name of employer Hotel

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER John Fischer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mag Germany

12. MAIDEN NAME OF MOTHER Magdalena Speck

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT George Fischer
(Address) 4130 Lee Place

15. FILED JAN -7 1927 19 Max C Starkcoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5th 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 6 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carbolic Acid Poisoning

Suicide (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 166

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? 4

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) H. W. Fath M.D.

1/7, 1927 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Irons

DATE OF BURIAL Jan 9th 1927

20. UNDERTAKER Math Hermann & Son 4103 Ft Pleasant

ADDRESS

...ormation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...n plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.