

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

Do not use this space.

18560

1. PLACE OF DEATH

County.....

Registration District No. **791**

1007

File No.

Township.....

Primary Registration District No.

Registered No. **4916**

City **St. Louis** (No. **1522 N. Harrison**)

St. **1522 N. Harrison**

Ward)

2. FULL NAME

John Jacob Fischer

(a) Residence No. **1522 N. Harrison** St. **21** Ward.

(If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE-OR
Catherine Fischer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 2 - 1863**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
65 **0**

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work **Foreman grading**
(b) General nature of industry, business, or establishment in which employed (or employer) **Morris Clay**
(c) Name of employer **retired**

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo**

PARENTS

10. NAME OF FATHER **Albert Fischer**

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

12. MAIDEN NAME OF MOTHER **unknown**

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

14. INFORMANT **Franc Fischer**
(Address) **1522 N. Harrison**

15. MAY - 5 1928
FILED **May 5 1928** **Wm C. Starkey** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 4 1928**

17. I HEREBY CERTIFY That I attended deceased from **Dec 22** 19**27** to **May 4** 19**28** that I last saw him alive on **May 3** 19**28** and that death occurred, on the date stated above, at **3 a.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronal Hemorrhage
22 Fr. (L. Frontal Fr.)
99% (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **Arteriosclerosis**
(duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? **no.** DATE OF.....

WAS THERE AN AUTOPSY? **no.**

WHAT TEST CONFIRMED DIAGNOSIS? **Plumbe**
(Signed) **Plumbe**, M. D.
, 19 (Address) **Morris Clay**

*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 **Calvary Cemetery** **May 7 1928**
DATE OF BURIAL

20. UNDERTAKER **Cullman Bros 1702 Grand St**
ADDRESS

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.

Dr. Harris

University Club

11 - 2