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

Do not use this space.

22239

1. PLACE OF DEATH — 791

County ..... Registration District No. 1003 ..... File No. 6421

Township St Louis ..... Primary Registration District No. ..... Registered No. ....

City St Louis Mo. (No. En route to City Hospt. ..... Ward)

2. FULL NAME Harry G. Lischer

(a) Residence. No. 1527 S. Benton St., 26 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) Sept 23 - 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	8	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Grocer 107
(b) General nature of industry, business, or establishment in which employed (or employer) 54
(c) Name of employer .....

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

PARENTS

10. NAME OF FATHER George L. Lischer

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

12. MAIDEN NAME OF MOTHER Pauline Sudhoetter

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

14. INFORMANT George L. Lischer
(Address) 1527 S. Benton St.

15. FILED JUN 18 1928 Wm C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1928

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 5:15 P.M. .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gun Shot Wounds Head
Suicide (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) While Suffering from Temporary Aberation
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemper, M. D.
6/18 1928 (Address) Dep. Coro.

*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	DATE OF BURIAL
Zions	June 18 1928
20. UNDERTAKER	ADDRESS
Hy Leidner Und Co N Market St.	1417

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.

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