

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

Do not use this space.

37561

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City St. Louis, Mo. (No. Bloumness Hospital St. _____ Ward)

File No. _____
 Registered No. **10642**

2. FULL NAME

Emma S. Fischer
 (a) Residence. No. 2617 Okansas, St., 17 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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 13th 1879

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>53</u>	<u>7</u>	<u>27</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Summersfield (STATE OR COUNTRY) Ills.

PARENTS
 10. NAME OF FATHER Phillip Fischer
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Barb. Miller
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany (STATE OR COUNTRY) _____

14. INFORMANT Julius V. Fischer (Address) 3157 Park Ave.

15. FILED NOV 11 1930 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 9th 1930

17. I HEREBY CERTIFY, That I attended deceased from October 23rd 1930 to 6th of Nov. 1930 that I last saw her alive on 4th of Nov. 1930 and that death occurred, on the date stated above, at 12:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes mellitus.

CONTRIBUTORY (SECONDARY) 5 M (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) Thos. Milk Brock M. D.
 (Address) 2266 S. Grand

*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 Falhalla DATE OF BURIAL Nov 16th 1930

20. UNDERTAKER Nancy Schmitt ADDRESS 3782 S. Grand

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.

