

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

Do not use this space.

1. PLACE OF DEATH

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

File No. **6417**
Registered No. **1246**
St. Ward.....

2. FULL NAME *Idell Louise Fischer*

(a) Residence, No. *St. Ann's Hospital* St. *6* 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 <i>Female</i> | 4. COLOR OR RACE <i>White</i> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) | | |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF | | | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Jan 17th - 1934</i> | | | | |
| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
| | | | <i>16</i> | |
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. | | | |
| | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. | | | |
| | 10. Date deceased last worked at this occupation (month and year) | | 11. Total time (years) spent in this occupation | |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Mo</i> | | | | |
| FATHER | 13. NAME <i>Unknown</i> | | | |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) | | | |
| MOTHER | 15. MAIDEN NAME <i>Hildegunde Fischer</i> | | | |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Illinois</i> | | | |
| 17. INFORMANT <i>Sister - Kemuzys</i> (ADDRESS) <i>St. Ann's Hospital</i> | | | | |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Cathary</i> DATE <i>2-3</i> 19 <i>34</i> | | | | |
| 19. UNDERTAKER <i>O. S. Halder</i> (ADDRESS) <i>3301 Page Ave</i> | | | | |
| 20. FILED <i>-3</i> 19 <i>34</i> 19. <i>J. B. Delecte</i> Registrar. | | | | |

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-2* 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 20* 19*34*, to *Feb 2* 19*34*.
I last saw her alive on *Feb 2* 19*34*. Death is said to have occurred on the date stated above, at *3:30 P.M.*
The principal cause of death and related causes of importance were as follows:
193 B Inanition
Enteritis
150

Other contributory causes of death

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) *J. B. Delecte* M. D.
(Address) *1467 Union Ave*

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.

THIS IS A PERMANENT RECORD

MAY 2 1934

