

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

Do not use this space.

SEP 7 1934

1. PLACE OF DEATH

County Jefferson
 Township Black
 City (No. _____) _____

Registration District No. 423
 Primary Registration District No. 5578

File No. 29819
 Registered No. 33
 _____ St. _____ Ward _____

2. FULL NAME

Ruth Fischer
 (a) Residence. No. Maxville Mo St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. 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) Aug 23 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 2 hrs. or 2 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kimmswick
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Henry Fischer

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

12. MAIDEN NAME OF MOTHER Leonor Kahler

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

14. INFORMANT Henry Fischer
 (Address) Kimmswick Mo

15. FILED Aug 24 1934 Phil J. Hink
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23 1934

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1934, to Aug 23 1934, to (that I last saw her alive on Aug 23 1934, and that death occurred, on the date stated above, at 2:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Birth
(7 months)

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 159
 IF NOT AT PLACE OF DEATH _____

4 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Erw. Siemig, M. D.
 , 19 (Address) Kimmswick Mo

*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 Bursuers DATE OF BURIAL Aug 24 1934

20. UNDERTAKER F H Heiligtag ADDRESS Kimmswick Mo

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.

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