

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.

SEP 16 1935

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

Do not use this space.

1. PLACE OF DEATH

County
Township
City (No. *6340 Laura*)

Registration District No. **791**
Primary Registration District No. **1003**

File No. *27942*
Registered No. **7007**
St. Ward)

2. FULL NAME *Mary Fischer*

(a) Residence, No. *6340 Laura* St., *7* 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 <i>Female</i>	COLOR OR RACE <i>White</i>	SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widow</i>
IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Frederick Fischer</i>		
DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Feb 16, 1838</i>		
AGE	YEARS <i>97</i>	MONTHS <i>6</i>
	DAYS <i>0</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Housework</i>	
	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	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 16 35*

22. I HEREBY CERTIFY, That I attended deceased from *July 1, 1935* to *Aug 16, 1935*
I last saw her alive on *Aug 16, 1935* Death is said to have occurred on the date stated above, at *8:45 pm*.

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis Date of onset *Don't know*

Other contributory causes of importance:

93

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

MOTHER FATHER 13. NAME *Unknown Dammann*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Mrs Anna Hooper 6340 Laura*

18. BURIAL, CREMATION, OR REMOVAL PLACE *New Bickens* DATE *8-19-35*

19. UNDERTAKER (ADDRESS) *Beneck Mechanics 1138 W 6 St*

20. FILED *AUG 18 1935* *J. F. Brebeck* Registrar.

Name of operation *none* Date of
What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

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

24. Was disease or injury in any way related to occupation of deceased? *no*
If so, specify

(Signed) *Roland R. Menon*, M. D.
(Address) *5330 Geraldine*

Memoria 000461

5330 Geraldine.

1-2-7-8-