

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.

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1003

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4349 Neosho St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Marie Fischer 2612
(b) If veteran, name war No
(c) Social Security No. No

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Frank Fischer
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased July 5 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 0 Days 0 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

FATHER { 12. Name Fred Steger
13. Birthplace Holland (City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Wittmann
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Fischer
(b) Address 4349 Neosho St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-39 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Hope Cem

18. (a) Signature of funeral director Frigo Chamber Mortuaries
(b) Address 6 1939 4228 So. Winifred Highway

19. (a) JUL 6 1939 (Date received local registrar)
(b) J. B. Bredel (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 15
(d) Street No. 4349 Neosho St. (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th
year 1939 hour 4¹⁵ minute A.M. M.

21. I hereby certify that I attended the deceased from July 2 to July 5, 1939.
that I last saw her alive on July 4 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Gastro-Enteritis
Due to unknown

Due to Acute Myocarditis
caused by acute gastroenteritis
Other conditions _____ (Includes pregnancy within 3 months of death)
Duration 4 days

Major findings: none
Of operations _____
Of autopsy none 120

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(a) Means of injury 1

23. Signature W. Sausbury (M. D. or other)
Address 258 Lafayette Date signed July 7 1939

Dr. W. F. Haliburton
3258 Lafayette
9-13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Edmund M. Bennett*

Licensed Embalmer No. *3024*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.