

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED APR 6 1945

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2850**

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St John's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 months  
In this community 35 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

Missouri  
(a) State Missouri (b) County St Louis  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1527 Benton St  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Martha Lischer

3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced. M  
6. (b) Name of husband or wife Paul  
6. (c) Age of husband or wife if alive 19 years  
7. Birth date of deceased July 19 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 9  
If less than one day hr. min.

9. Birthplace Washington Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER { 12. Name Frederick Fricke  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Wilhelmina Ott  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Herbert Lischer (Son)  
(b) Address 4253a Red Bud

17. (a) Burial (b) Date thereof March 31 45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Mo

18. (a) Signature of funeral director Beiderwieden F H Inc  
(b) Address 1936 St Louis Avenue

19. (a) MAR 23 1945 J. F. Brebeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28  
year 1945 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from 5-2 1944 to 3-28 1945.  
that I last saw h. er alive on 3-27 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Carcinoma of Caecum  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Duration  
1 plus years

Major findings: 72744 - Inoperable Ca. involving Caecum adjacent to pelvis, pelvic & leg vessels.  
Of operations.....  
Of autopsy.....

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)  
(c) Means of injury.....  
23. Signature Melvin Jessa (M. D. or other) M.D.  
Address 3611 St. Louis Ave Date signed 3-28-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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..... *Glen W. Katz* .....

Licensed Embalmer No..... *3737* .....

P. O. Address..... *1936 N. Louis Ave* .....

**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, fact should be so stated above.**