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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

21897

State File No. 6008

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital #1. 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000 23

(c) City or town St. Louis. 17 (If outside city or town limits, write "RURAL")

(d) Street No. 1303 a Ann Av. 9 (If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sarah Fischer

3. (b) If veteran, name war No

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John A. Fischer

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased About (Month) (Day) 1885 (Year)

8. AGE: Years 60 Months Unknown Days If less than one day hr. min.

Abt

9. Birthplace St. Louis. Missouri 0 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Duggan

13. Birthplace St. Louis. Missouri. 0 (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Sarah Cahill

15. Birthplace Ireland 11 (City, town, or county) (State or foreign country)

16. (a) Informant John A. Fischer

(b) Address 1303 a Ann Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park.

18. (a) Signature of funeral director Wm C. Mitchell

(b) Address 1926 Allen Av.

19. (a) JUL 10 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10th year 1945 hour 9:25 minute A. M.

21. I hereby certify that I attended the deceased from 7/5/45, 19, to 7/10/45, 19; that I last saw her alive on 7/10/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Hemorrhage from lenticulo striate artery due to arteriosclerosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Herbert C. Fritz (M. D. or other)

Address 1515 Lafayette Date signed 7/10/45

(Licensed Embalmer's Statement on Reverse Side)

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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen 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.