

FILED MAY 17 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18045

State File No. 4269

|  |  |   |   |  |   |  |   |  |
|--|--|---|---|--|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>318</u>   |   | PRIMARY REG. DIST. NO. <u>1003</u>   |   | Registrar's No. <u>4269</u>  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u><br>b. COUNTY _____ |   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>  |  | c. LENGTH OF STAY (In this place) <u>4 yrs.</u>   |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>                                    |   | <u>2069</u>  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1909 Arlington Ave.</u>   |  |   |   | STREET ADDRESS (If rural, give location) <u>1909 Arlington Ave.</u>  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) <u>Rudolph</u>  |  |   | a. (First) _____                                  |  | b. (Middle) <u>---</u>  |  | c. (Last) <u>Fischer</u>  |  |
| 4. DATE OF DEATH <u>MAY 4 1951</u>   |  | Month <u>MAY</u> Day <u>4</u> Year <u>1951</u>  |   | 5. SEX <u>male</u>   |   | 6. COLOR OR RACE <u>white</u>  |   |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>  |  | 8. DATE OF BIRTH <u>July 2 1871</u>   |   | 9. AGE (In years last birthday) <u>79</u>  |   | IF UNDER 1 YEAR Months _____ Days _____                                |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____   |   | 11. BIRTHPLACE (State or foreign country) <u>Washington Mo.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U</u>                                  |   |  |
| 13a. FATHER'S NAME <u>Herman Fischer</u>   |  |   | 13b. MOTHER'S MAIDEN NAME <u>Marie Arcularios</u> |  |   | 14. NAME OF HUSBAND OR WIFE <u>Elizabeth Fischer</u>                   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>  |  | 16. SOCIAL SECURITY NO. _____   |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Marre Bayless, 1909 Arlington</u>  |   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arterio-sclerosis</u><br>DUE TO (c) <u>Ch. Myocarditis</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Hypertension</u> |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u><br><u>6 yrs</u><br><u>6 mths</u><br><u>6 yrs.</u> |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |   | 21f. HOW DID INJURY OCCUR? <u>H201</u>                                 |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>3/12</u> , 19 <u>51</u> , to <u>May 4</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>51</u> , and that death occurred at <u>7:55p</u> m., from the causes and on the date stated above. |  |   |   |  |   |  |   |  |
| 23a. SIGNATURE <u>Therese Greener, M.D.</u> (Degree or title)  |  |   |   | 23b. ADDRESS <u>4500 Olive St.</u>   |   | 23c. DATE SIGNED <u>5/6/51</u>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  |  | 24b. DATE <u>5/7/51</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>  |   | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> |   |  |
| DATE RECEIVED BY LOCAL HEALTH DEPT. <u>MAY 1951</u>  |  | REGISTRAR'S SIGNATURE <u>J. B. Luster</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral, 1905 Union Blvd.</u>  |   |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. T. Greiner,  
11ster Bldg.

(1 to 3:30)

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.....

working under my personal supervision.

Student Embalmer No.....

Signed Warren A. Carver

Signed.....  
Student Embalmer

Licensed Embalmer No. 3534

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, fact should be so stated above.