

FILED DEC 1 1951

THE DIVISION OF HEALTH OF INDIANA
STANDARD CERTIFICATE OF DEATH

38995

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1005 Registrar's No. 10170

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Indiana</u> b. COUNTY <u>Marion</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Indianapolis</u> <u>8136</u> | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u> | | d. STREET ADDRESS (If rural, give location) <u>RR 10, Box 316</u> | |

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|-------------------------------------|---------------------------|------------------------|--------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Marlene</u> | b. (Middle) <u>Mae</u> | c. (Last) <u>Fischer</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 15, 1951</u> |
|-------------------------------------|---------------------------|------------------------|--------------------------|--|

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|----------------------|-------------------------------|---|---------------------------------------|---|-----------------------|-----------------------|---------------------|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u> | 8. DATE OF BIRTH <u>Feb. 18, 1931</u> | 9. AGE (In years) (Last birthday) <u>20</u> | # UNDER 1 YEAR Months | # UNDER 24 HRS. Hours | # UNDER 1 MIN. Min. |
|----------------------|-------------------------------|---|---------------------------------------|---|-----------------------|-----------------------|---------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student Nurse</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Indianapolis, Ind.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
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| 13a. FATHER'S NAME <u>Carl A. Fischer</u> | 13b. MOTHER'S MAIDEN NAME <u>Henrietta Siebert</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>306-30-4570</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Henrietta Fischer, Indianapolis, Ind.</u> | ADDRESS <u>Ind.</u> |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Failure</u> | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <u>Ascending Paralysis</u> rise to the above cause (a) stating the underlying cause last. DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION <u>11-10-51</u> | 19b. MAJOR FINDINGS OF OPERATION <u>Tracheotomy</u> | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>357x</u> |

22. I hereby certify that I attended the deceased from 11-9-1951 to 11-15-1951, that I last saw the deceased alive on 11-15-1951, and that death occurred at 7:00 P.M., from the causes and on the date stated above.

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|---|-----------------------------------|----------------------------------|
| 23a. SIGNATURE <u>Joseph E. Conroy M.D.</u> | 23b. ADDRESS <u>906 Olive St.</u> | 23c. DATE SIGNED <u>11-15-51</u> |
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|--|---------------------------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 24b. DATE <u>11-15-51</u> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) <u>Indianapolis, Ind.</u> |
|--|---------------------------|------------------------------------|---|

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|---|--|---|--------------------------------------|
| DATE REC'D BY LOCAL REG. <u>NOV 13 1951</u> | REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> | ADDRESS <u>4700 Washington Blvd.</u> |
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WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed.....

Licensed Embalmer No.....

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.