

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21979**  
Registrar's No. **5871**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE **Missouri** b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis, Mo.**

c. LENGTH OF STAY (in this place) **1 Week**  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis** **2099**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Deaconess Hospital**

d. STREET ADDRESS (If rural, give location) **6018 Thekla Avenue**

3. NAME OF DECEASED  
a. (First) **Clarence** b. (Middle) **J.** c. (Last) **Fishing**

4. DATE OF DEATH (Month) (Day) (Year)  
**June 21, 1952.**

5. SEX **Male**

6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Aug. 16, 1892**

9. AGE (In years last birthday) **59**

IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Officer**

10b. KIND OF BUSINESS OR INDUSTRY **Police**

11. BIRTHPLACE (State or foreign country) **St. Louis, Mo.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **John Fishing**

13b. MOTHER'S MAIDEN NAME **Augusta Hoffmeister**

14. NAME OF HUSBAND OR WIFE **Mrs. Amanda Fishing**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
**Amanda Fishing, 6018 Thekla Ave.**

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  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Carcinomatosis**  
  
ANTECEDENT CAUSES **Carcinoma of Urinary Bladder**  
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH  
**6 months**  
  
**14 months**

19a. DATE OF OPERATION \_\_\_\_\_

19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_

20. AUTOPSY? YES  NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **181X**

22. I hereby certify that I attended the deceased from **May 20, 1952, to June 21, 1952**, that I last saw the deceased alive on **June 21, 1952**, and that death occurred at **4:00 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE **Clarence E. Mueller, M.D.** (Degree or title)

23b. ADDRESS **631 N. Grand Blvd.**

23c. DATE SIGNED **6-23-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**

24b. DATE **6-24-1952.**

24c. NAME OF CEMETERY OR CREMATORY **New St. Marcus Cemetery**

24d. LOCATION (City, town, or county) (State) **St. Louis, County Mo.**

DATE REC'D BY LOCAL \_\_\_\_\_ **JUN 24 1952**

REGISTRAR'S SIGNATURE **J. Carl Smith**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
**Math Hermann & Son Inc. 2161 E. Fair Ave.**

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

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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 *Richard H. Burnley*

Licensed Embalmer No. *4302*

P. O. Address *St. Louis Mo.*

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.