

STANDARD CERTIFICATE OF DEATH

State File No. 2764

FILED JAN 19 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2129	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 2 yrs.		d. STREET ADDRESS (If rural, give location) 5351 Delmar Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital			

3. NAME OF DECEASED (Type or Print) Barbara		a. (First) b. (Middle) c. (Last) Fischer		4. DATE OF DEATH (Month) (Day) (Year) 1-1-1954	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH Aug-31-1870	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and State or Foreign Country) Mittelheim, Germany 4	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME John Brand		13b. MOTHER'S MAIDEN NAME Helena Engelhard		14. NAME OF HUSBAND OR WIFE John Fischer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 499-26-5007B		17. INFORMANT'S SIGNATURE OR NAME Supt. Robertson	
				ADDRESS Masonic Home of Missouri, 5351 Delmar	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		ANTECEDENT CAUSES DUE TO (b) Hypertension			3 Weeks
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			2 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X		

22. I hereby certify that I attended the deceased from 2-15-51, 19 51, to 1-1-54, 19 54 that I last saw the deceased alive on 12-31-19 53, and that death occurred at 7.30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Carl Smith MD</i>		23b. ADDRESS 508 N. Grand Blvd.		23c. DATE SIGNED 1-1-1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/4/54		24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri	

DATE REC'D BY LOCAL REG. JAN 4 1954		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 No. Grand Bl	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L.

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.