

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2767

FILED FEB 2 1954

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0611**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY 2019 | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN St. Louis | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or Print) MABEL | | | a. (First) FISSINGER | | b. (Middle) | | |
| | | | c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) JANUARY 17, 1954 | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH 12-13-1888 | |
| 9. AGE (In years last birthday) 65 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | 11. BIRTHPLACE (City and State or Foreign Country) Kansas | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13a. FATHER'S NAME unknown | | 13b. MOTHER'S MAIDEN NAME Nettie McClemons | | 14. NAME OF HUSBAND OR WIFE Gerald Fissinger | | | |
| 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. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gert Soroka, 132 S. Kirkwood av | | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL THROMBOSIS ANTECEDENT CAUSES 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. PNEUMONIA | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 332x | | | |
| 22. I hereby certify that I attended the deceased from 1-6-54 , 19____, to 1-17-54 , 19____, that I last saw the deceased alive on 1-17-54 , 19____, and that death occurred at 2:10P m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) Paul U. Larson M.D. | | | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 1-18-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 1-20-54 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem. | | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | |
| DATE REC'D BY LOCAL REG. JAN 20 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lahey F.H., Madison, Ill. | | | |

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.....
Signature of Student Embalmer

Signed.....
Ronald O. Yakup

Licensed Embalmer No.....*3*

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

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.