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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27659

State File No.

FILED SEP 8 1955

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> 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) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>12 Kingsway Hotel 108 N. KINGS HIGHWAY</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u>		b. (Middle) <u>FRELICH</u>		c. (Last) <u>FISHER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22, 1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>Abt. 73</u>		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Hours _____		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>New York, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Paul Schwartz</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Samuel Fisher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Joseph Smith-7343 Dartmouth</u>			
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) <u>Pulmonary Edema</u> ANTECEDENT CAUSES - Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> 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 <u>A hour</u> <u>Unknown</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		420.0	
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) <u>St. Louis St. Louis, Mo.</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"/>		21f. HOW DID INJURY OCCUR? <u>5 PM to 6:35 PM.</u>					
22. I hereby certify that I attended the deceased from <u>Aug 22</u> , 19 <u>55</u> , to _____, 19____, that I last saw the deceased alive on <u>Aug 22</u> , 19 <u>55</u> , and that death occurred at <u>6:35 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. E. Holmes</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Jewish Hospital St. Louis, Mo</u>		23c. DATE SIGNED <u>Aug 23, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>8/24/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
DATE REC'D BY LOCAL REG. <u>AUG 23 1955</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman Rindskopf, Inc., 5216 Delmar</u>			

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 *John B. Dubrovnik*

Licensed Embalmer No. *369*

P. O. Address *Stoney N.*

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.