

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

State File No. **28372**  
**7516**

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |  | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution—residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>   |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |  | c. LENGTH OF STAY (in this place) <b>12 days</b>   |  | c. CITY OR TOWN <b>Hillsdale</b>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>   |  |  |  | e. STREET ADDRESS (If rural, give location) <b>6224 Greer Avenue.</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>NETTIE</b> b. (Middle) <b>ELIZABETH</b> c. (Last) <b>FISHER</b>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>August 13, 1956</b> |   |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   |  | 8. DATE OF BIRTH <b>March 4, 1884</b>  |  |
| 9. AGE (In years last birthday) <b>72</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Wabash County, Illinois</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 13a. FATHER'S NAME <b>Isaac Harness</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Mary Ann Geisler</b>   |  | 14. NAME OF HUSBAND OR WIFE <b>Earl Fisher</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>   |  | 16. SOCIAL SECURITY NO. <b>none</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Irene Bradson, Midway, Pennsylvania</b>   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Postoperative Atelectasis</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Exploratory Laparotomy</b><br>DUE TO (c) <b>Cardiac arrest</b><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>  |  |
| 19a. DATE OF OPERATION <b>8/10/56</b>   |  | 19b. MAJOR FINDINGS OF OPERATION <b>585x</b>   |  |   |  | 20. AUTOPSY? YES <input checked="" 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. HOW DID INJURY OCCUR? _____   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22. I hereby certify that I attended the deceased from <b>8/1, 1956</b> , to <b>8/13, 1956</b> , that I last saw the deceased alive on <b>8/13, 1956</b> , and that death occurred at <b>I.P.</b> m., from the causes and on the date stated above. |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>John D. Bauer M.D.</b>  |  |  |  | 23b. ADDRESS <b>2415 N. Kingshighway</b>  |  | 23c. DATE SIGNED <b>8/14/56</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |  | 24b. DATE <b>Aug 16, 1956</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>Mt. Carmel, Illinois</b>  |  |
| DATE REC'D BY LOCAL REG. <b>AUG 14 1956</b>   |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Shepard Funeral Home, 1167 Hamilton Ave.</b>  |  |  |  |

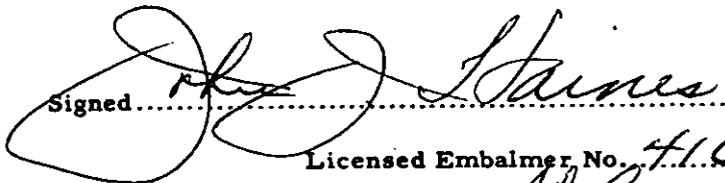
Letter from Dr. Della - exploratory was for malignancy

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.....  


Licensed Embalmer No. 4100

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