

Health,  
& Welfare  
S. Public  
th Service

FILED NOV 22 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

41967  
STATE FILE NUMBER  
10921

Registration District No. 318 Primary Registration District No.

Registrar's No.

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>4504 Harris Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THEODORE</b> First <b>JOHN</b> Middle <b>FISCHER</b> Last			4. DATE OF DEATH Month <b>NOV.</b> Day <b>14,</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1902</b>	9. AGE (In years last birthday) <b>55</b>	10. F UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Invalid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Spray Painter</b>		11. BIRTHPLACE (City and state or country) <b>Donoplin, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Esther L. Fischer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. Esther L. Fischer</b>		Address <b>4504 Harris Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b> <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>345x</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>11/8/57</b> to <b>11/14/57</b> and last saw her alive on <b>11/14/57</b> Death occurred at <b>3:40 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Joseph Drew Callahan M.D.</b> (Degree or title)			22b. ADDRESS <b>1515 LA FAYETTE AVE.</b>		22c. DATE SIGNED <b>11/14/57.</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Nov. 18, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son, Inc. 2161 E. Fair</b>			25. DATE RECD. BY LOCAL REG. <b>NOV 15 57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
X by me, or by ....., Student Embalmer No. ....  
working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed

*Clement McQuay*

Licensed Embalmer No. 3732

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.