

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041541
STATE FILE NUMBER
11260
Registrar's No.

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST LOUIS,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 CITY HOSPITAL # 1		Length of stay in 1b 1	d. STREET ADDRESS (If outside, give location) 4119 4525 MAFFITT AVE
3. NAME OF DECEASED (Type or print) First Middle Last ELIAS GEORGE FISHER			4. DATE OF DEATH Month Day Year NOV, 20, 1958
5. SEX MALE 0	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 22, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last day) 58 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11a. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME HENRY FISHER		13b. MOTHER'S MAIDEN NAME IDA LOTTMANN	14. NAME OF HUSBAND OR WIFE CLARA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify uniform) (If yes, give way or dates of service)		16. SOCIAL SECURITY NO. 492-09-1029	17. INFORMANT Address CLARA FISHER 4525 MAFFITT AVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAY CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>July 1956</u> to <u>present</u> and last saw <u>him</u> alive on <u>OCT 1</u> Death occurred at <u>1 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James P. Sullivan MD</u> (Degree or title)		22b. ADDRESS <u>2314 Tulyugh Pl</u>	22c. DATE SIGNED <u>11-21-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/24/58	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI
24. FUNERAL DIRECTOR ADDRESS STROOT, - GARROLL 4600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. NOV 24 '58	26. REGISTRAR'S SIGNATURE <u>J Pearl Smith in D.</u> S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *M W Ruster*

Licensed Embalmer No. *4865*

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.