

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007097

STATE FILE NUMBER

2 2097

FILED MAR 10 1959

Registration District No. Primary Registration District No.

Registrar No.

300
-57
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I

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2414 N. 15th, St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last FISHER			4. DATE OF DEATH Month FEBRUARY Day 26 Year 1959		
5. SEX Male	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 26, 1929	9. AGE (In years last birthday) 29 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Punch Press Operator		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sangamon, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Dale Fisher		13b. MOTHER'S MAIDEN NAME Ruby Green		14. NAME OF HUSBAND OR WIFE Shirley Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean War		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Shirley Fisher, 2414 N. 15th St. Springfield, Ill.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (b) POST-OP CLOSURE OF INTERVENTRICULAR SEPTAL DEFECT INTERVENTRICULAR SEPTAL DEFECT, CONGENITAL, WITH SEVERE PULMONARY HYPERTENSION DUE TO (c) SEVERE PULMONARY HYPERTENSION					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			754.2		
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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 SEPT. 6, 1958 to FEB. 26, 1959 and last saw her/him alive on FEB. 26, 1959 Death occurred at 11:50 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Dress or title) <i>C. D. Vanellian, M.D.</i>			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 2/26/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-27-59	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Springfield, Illinois.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 "ashington, Blvd.			25. DATE RECD. BY LOCAL REG. FEB 27 '59		26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

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 *Lawrence O. Herling*

Licensed Embalmer No. *4979*
P. O. Address *St. Louis, Mo.*

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.