

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041825

FILED VS DEC 7 1959

210647

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No.

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5135 Dresden Ave. | | d. STREET ADDRESS (If outside, give location) 5135 Dresden Ave. | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE J. FISLER | | | 4. DATE OF DEATH Month Day Year Nov. 14 1959 | | |
|--|--|--|--|--|--|

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|----------------|---------------------------|---|--------------------------------|------------------------------|---|----------------|
| 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 10-14-1897 | 9. AGE (last birthday) 62 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|----------------|---------------------------|---|--------------------------------|------------------------------|---|----------------|

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|---|-----------------------------------|--|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender-Cologne Tavern | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME George J. Fisler | 13b. MOTHER'S MAIDEN NAME Augusta Tetz | 14. NAME OF HUSBAND OR WIFE Barbara Magdalena Fisler |
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|---|---------------------------------|------------------------------------|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Barbara M. Fisler | Address 5135 Dresden Ave. |
|---|---------------------------------|------------------------------------|------------------------------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH 3 Months? |
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IMMEDIATE CAUSE (a) Cancer of Throat

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) ?
DUE TO (c) Had no previous treatment

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
No.

PART III. If deceased was female was there a pregnancy in last 90 days.
148x
 Yes No Unknown

| | | |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 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.) |
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|--|--|--|--|
| 20c. TIME OF INJURY Hour Month, Day, Year p.m. | 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 |
|--|--|--|--|

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| 21. I attended the deceased from Nov 12 1959 to Nov 9th and last saw her/him alive on Nov 9th 1959 Death occurred at 8:10 P. m on the date stated above, and to the best of my knowledge, from the causes stated. |
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|---------------------------------------|-------------------|---|------------------------------|
| 22a. SIGNATURE Joseph Davie - M.D. | (Degree or title) | 22b. ADDRESS St. Louis - 8 4615 Lindell Blvd. | 22c. DATE SIGNED 11-18-59 |
|---------------------------------------|-------------------|---|------------------------------|

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|--|-----------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
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| 24. FUNERAL DIRECTOR Kriegshauser 4228 S.Kingshighway | ADDRESS | 25. DATE RECD. BY LOCAL REG. NOV 18 1959 | 26. REGISTRAR'S SIGNATURE Earl Smith. M.D. |
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DOCUMENT

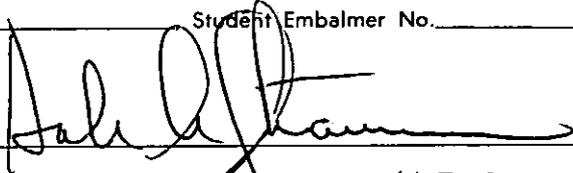
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. 4533

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.