

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-003379**

**FILED VS FEB 5 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 852** STATE FILE NUMBER

2-11-60

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10-11-60

BY AFFIDAVIT OF attending physician MEDICAL CERTIFICATION DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>Life</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FIRMIN DESLOVE</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4300 Mr. Pearson</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>								
a. NAME OF DECEASED (Type or print) <b>Cecelia Lucille Fisher</b>				4. DATE OF DEATH Month <b>JAN</b> Day <b>24</b> Year <b>1960</b>											
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W.</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/25/1897</b>		9. AGE (last birthday) <b>62 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <b>Oper. Mkt. Car Loading Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>				11. BIRTHPLACE (City and state or country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME <b>John Hartnett</b>				13b. MOTHER'S MAIDEN NAME <b>Nora Byrne</b>				13c. NAME OF HUSBAND OR WIFE <b>John 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</b>				16. SOCIAL SECURITY NO. <b>490-12-8587</b>				17. INFORMANT <b>Mr. Charles J. Dyer, 8809 Signature Lane</b>				Address			
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>CHRONIC CONGESTIVE FAILURE</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>					
DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DIS</b>										<b>4 YRS</b>					
DUE TO (c) <b>443L</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC PYELONEPHRITIS</b>										PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
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 _____ 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 <b>OCT 26, 1959</b> to <b>JAN 24, 1960</b> and last saw her/him alive on <b>JAN 24, 1960</b> Death occurred at <b>9:50 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <b>Quinton J. Wick, M.D.</b>				22b. ADDRESS <b>1325 S. GRAND</b>				22c. DATE SIGNED <b>1-24-60</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/27/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>							
24. FUNERAL DIRECTOR <b>Edward J. Normelly, 3840 Lindell Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 25 1960</b>				26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>							

2000-0077

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.