

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 28 1960

-60-016495

Registration District No. 310 Primary Registration District No. 5058 Registrar's No. 88

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>ST. CHARLES</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. CHARLES</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. CHARLES</u>		Length of stay in 1b <u>50YRS</u>		c. CITY OR TOWN <u>ST. CHARLES</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPHS HOSP</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>919 No. SIXTH STR</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULU ETHEL FISCHER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 15 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 23, 1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>3 22</u>	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>IN OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>WAYVERLY ILL</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BENJAMIN CLARK</u>			13b. MOTHER'S MAIDEN NAME <u>HURT</u>		14. NAME OF HUSBAND OR WIFE (DECEASED) <u>H.A. ROBERT FISCHER 1927</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO NOT</u>			16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>ROBERT C. FISCHER, ST. CHARLES, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Emboli</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>?</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) <u>Massive Gastrointestinal Bleeding.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
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 <u>Dec 1955</u> to <u>April 15, 1960</u> and last saw her <u>live</u> on <u>April 14, 1960</u> Death occurred at <u>5:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul H. Archer M.D.</u>				22b. ADDRESS <u>St. Charles, Mo</u>		22c. DATE SIGNED <u>4-15-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>APRIL 18, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CATH. CEM.</u>		23d. LOCATION (City, town, or county) <u>ST. CHARLES</u>		STATE <u>Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>C.L. PRINSTER. ST. CHARLES, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>APR 19-60</u>	26. REGISTRAR'S SIGNATURE <u>Maureen Wilson</u>		

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 Howard O Kessler

Licensed Embalmer No. 4631

P. O. Address Wentzville

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.