

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Pagedale
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7225 St. Charles Rock Rd.

3. NAME OF DECEASED (Type or print) First William Middle M. Last Fisher			4. DATE OF DEATH Month September Day 21 Year 1960		
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 3/4/1884	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Monument Co.	11. BIRTHPLACE (City and state or country) Phelps Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.	

13a. FATHER'S NAME Euriah Fisher		13b. MOTHER'S MAIDEN NAME Margaret Southard		14. NAME OF HUSBAND OR WIFE Lathoria Fisher	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 186-38-7797		17. INFORMANT William H. Fisher, 207 Innisfail, Web. Gr., Mo.	

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 4 hrs
IMMEDIATE CAUSE (a) Cancer of Liver			
DUE TO (b) (Origin unknown)			
DUE TO (c) 156.2			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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		
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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 5:30 a.m. p.m. Month, Day, Year 8/20/60	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.) St. Louis, Mo.	20f. CITY, TOWN, OR LOCATION St. Louis, Mo.	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from 8/20/60 to 9/21/60 and last saw her/him alive on 9/20/60 . Death occurred at 5:30 am on the date stated above, and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE Ralph Berglund (Degree or title)			22b. ADDRESS 32038 Grand		22c. DATE SIGNED 9/21/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-23-60	23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	23d. LOCATION (City, town, or county) St. James, Mo.
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24. FUNERAL DIRECTOR Licklider Funeral Home, St. James, Mo.	25. DATE RECD. BY LOCAL REG. SEP 21 1960	26. REGISTRAR'S SIGNATURE Loan 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. W. D. Embler
Licensed Embalmer No. _____
P. O. Address St. Louis

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