RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH 60-039727

FILED VS OCT 19 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9855 STATE FILE NUMBER 60-039727

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS Mo
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. JOHN'S Hosp.
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2844 a S. 18th
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First KIMBERLY Middle E. Last FISCHER
4. DATE OF DEATH: Month OCT. Day 8 Year 1960
5. SEX: Female
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: DEC. 11 1959
9. AGE (last birthday): —
IF UNDER 1 YEAR: Months 9 Days 27
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): ST. LOUIS Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: JOSEPH FISCHER
13b. MOTHER'S MAIDEN NAME: PATRICIA BYRD
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: JOSEPH FISCHER Address: 2844 a S. 18th

MEDICAL CERTIFICATION

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 decompensation — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cardiac Arrest (2x)
DUE TO (c): Surgery for Megalo-ureter — 9 months.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 757.3
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Oct. 1, 1960 to Oct. 8, 1960 and last saw her alive on Oct. 8, 1960
Death occurred at 11:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Eugene T. Dmytryk, M.D.
22b. ADDRESS: University Club Bldg
22c. DATE SIGNED: 10-9-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: OCT. 11 1960
23c. NAME OF CEMETERY OR CREMATORY: CALVARY CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo

24. FUNERAL DIRECTOR: Thomas Kuter ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: OCT 11 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Ba

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