

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035257

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2634 STATE FILE NUMBER

AMENDED

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON Mo.</u>		Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>Clayton</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>8130 Vena Ave</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8130 Vena Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>GUSSIE</u> Middle <u>B.</u> Last <u>FISCHER</u>			4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>WW</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>6/2/77</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>(UNKNOWN) BERLINGER</u>		13b. MOTHER'S MAIDEN NAME <u>(UNKNOWN) LEV IS</u>		14. NAME OF HUSBAND OR WIFE <u>JACOB S. (deceased)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>JOSEPH S. FISCHER 8130 Vena Ave</u>		

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
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			<u>6 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic heart disease</u>		<u>years</u>
	DUE TO (c) <u>Hypertension</u>		<u>years</u>
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 checked="" type="checkbox"/> No <input type="checkbox"/> 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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ 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 _____

21. I attended the deceased from 1945 to Sept. 16-1961 and last saw her alive on Sept 16-1961
Death occurred at 10:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harman W. Meyer M.D.</u>		22b. ADDRESS <u>4409 West Pine Blvd</u>		22c. DATE SIGNED <u>9/18/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>9/18/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai</u>		23d. LOCATION (City, town, or county) (State) <u>8400 Gravois Ave</u>
24. FUNERAL DIRECTOR ADDRESS <u>MAYER 4356 Lindell Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>9-19-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</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 Oliver T. Sedwell

Licensed Embalmer No. 4047

P. O. Address St. Louis

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.