

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017611

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4026 STATE FILE NUMBER

FILED APR 17 1963

VS 300 Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson Co.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>Imperial, Mo.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>3520 Chippewa St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Male (Steve) Fischer</u>		4. DATE OF DEATH Month Day Year <u>April 9 63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Anthony C. Fischer</u>		13b. MOTHER'S MAIDEN NAME <u>Myra Jean Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>no</u>		16. SOCIAL SECURITY NO. [redacted]	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Intracranial Bleeding</u>		14. NAME OF HUSBAND OR WIFE <u>Anthony C. Fischer, Imperial, Mo.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>7600</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.)	
21. I attended the deceased from <u>4/9/63</u> to <u>4/9/63</u> and last saw ^{her} _{him} alive on <u>4/9/63</u>		20f. CITY, TOWN, OR LOCATION COUNTY: STATE	
22a. SIGNATURE (Degree or title) <u>Robert A. Brennan M.D.</u>		22b. ADDRESS <u>3654 So. Grand, St. Louis, Mo.</u>	
22c. DATE SIGNED <u>4/10/63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>4/10/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Rock Creek, Mo.</u>		24. FUNERAL DIRECTOR <u>Heiligtag Funeral Home, Imperial, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>APR 10 1963</u>		26. REGISTRAR'S SIGNATURE <u>Robert A. Brennan M.D.</u>	

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 Elmer Halistag

Licensed Embalmer No. 3571

P. O. Address Imperial MO

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.