

FILED APR 12 1956

## STANDARD CERTIFICATE OF DEATH

State File No. 11607

318

1003

Registrar's No. 3113

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 11607	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton 5 Missouri</u>		<u>4452</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>#5 Hillvale Drive -</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SAMUEL</u> b. (Middle) <u>BROWNELL</u> c. (Last) <u>WESTLAKE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 27 1956</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>February 9, 1879</u>		9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days	IF UNDER 11 HRS. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>medical</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Westlake</u>		13b. MOTHER'S MAIDEN NAME <u>Antoinette Powell</u>		14. NAME OF HUSBAND OR WIFE <u>Beulah Westlake</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Beulah Westlake #5 Hillvale Clayton 5, Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic myocarditis</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 day - 5 years.</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>420:1</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1952</u> to <u>3-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>56</u> , and that death occurred at <u>1:20</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>M. Norman Orzel M.D.</u>			23b. ADDRESS <u>508 North Grand Ave</u>			23c. DATE SIGNED <u>3/27/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>Mar 29, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County - Mo.</u>			
DATE RECD BY LOCAL REG. <u>MAR 28 1956</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. R. Lupton and sons 7233 Delmar Blvd</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 \_\_\_\_\_  
Student Embalmer

Signed

*Arnold W. Schiener*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.