

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041583

FILED VS DEC 7 1959

210877

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

NDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 59 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Word			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6041 Washington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOSEPH (AKA JOE) BOXER				4. DATE OF DEATH Month Nov. Day 23 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) Russia		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Ike Boxer			13b. MOTHER'S MAIDEN NAME Anna			14. NAME OF HUSBAND OR WIFE Box			
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. Unk.		17. INFORMANT Mrs. J.H. Clanahan		Address 711 Taveres, Fla.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Thyroid							INTERVAL BETWEEN ONSET AND DEATH 16 yrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Carcinoma of Brain metastasis							Interval 2 months		
DUE TO (c) 194x									
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			
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.	Month, Day, Year _____								
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 Jan 1943 to 1-23-59 and last saw him alive on 11-23-59 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Sherman J. Klecker M.D.				22b. ADDRESS 9616 Bachland Rd				22c. DATE SIGNED 11-24-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 11/25/59	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) University City, Mo.				
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson				25. DATE RECD. BY LOCAL REG. NOV 24 1959		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.			

DOCUMENT

MEDICAL CERTIFICATION

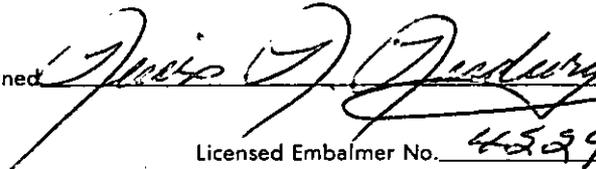
BY AFFIDAVIT OF

mjb

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 4539

P. O. Address _____

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.