

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031425  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2164

AMENDED

FILED SEP 1 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>Koch</u>	Length of stay in 1b <u>14 days</u>	c. CITY OR TOWN <u>St. Louis</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>Robert Koch Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>5028 S. 37th ST.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph (Salie or Sall)or</u> Middle <u>Salih</u> Last <u>Salih</u>	4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1961</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>2-14-1990</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAINTENANCE MAN CITY OF ST LOUIS</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CITY OF ST LOUIS</u>	11. BIRTHPLACE (City and state or country) <u>Syria</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>John Salih</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Annie SALIH</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>WINNIE MIERZEJEWSKI 5028 SO. 37th ST.</u>	Address
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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>ACUTE GASTROENTERITIS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>SENILITY</u>	
DUE TO (b)	<u>571-1</u>	
DUE TO (c)		

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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <u>4:15</u> a.m. <u>AM</u> Month, Day, Year <u>7. 18. 1961</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Koch - Mo</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>7. 18. 1961</u> to <u>7. 31. 61</u> and last saw her/him alive on <u>7. 31. 61</u> Death occurred at <u>4:15 A.M</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Dr. James M.O.</u> (Degree or title)	22b. ADDRESS <u>R. Koch Hosp. Koch - Mo</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG 3. 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
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24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-2-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF CALIFORNIA

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH SERVICES  
DIVISION OF PROFESSIONAL REGULATION  
EMBALMERS

**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 Eleana Province

Licensed Embalmer No. 3403

P.O. Address 2906 graves

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.