

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007749
STATE FILE NUMBER

AMENDED

Registration District No. **318**
FILED MAR 7 1962

Primary Registration District No. **1003**

Registrar's No. **2342**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 3 1/2 Wks.	c. CITY OR TOWN University City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med. Center		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6286 Cates Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MARY Middle BEITCHMAN Last			4. DATE OF DEATH Feb. 28, 1962 Month Day Year	
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5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unk.	9. AGE (last birthday) ab. 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Poland	12. CITIZEN OF WHAT COUNTRY Poland
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13a. FATHER'S NAME Israel Frank	13b. MOTHER'S MAIDEN NAME Pauline (unk)	14. NAME OF HUSBAND OR WIFE Isadore
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Isadore Beitchman Address 6286 Cates
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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: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) 493x	

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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **2-1-62** to **2-27-62** and last saw her/him alive on **2/25/62**
Death occurred at **2-27-62 at 6:30 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph Lent (ID agree or title) M.D.	22b. ADDRESS 8515 Dalmay St Louis Mo	22c. DATE SIGNED 2/27/62
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23a. BURIAL CREMATION, REMOVAL (Specify) Rem.	23b. DATE 2/28/62	23c. NAME OF CEMETERY OR CREMATORY Chebra Kadisha	23d. LOCATION (City, town, or county) (State) University City, Mo.
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24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson ADDRESS	25. DATE RECD. BY LOCAL REG. FEB 27 1962	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 *Edward J. White*

Licensed Embalmer No. 3988

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.