

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2547-62-007916  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2547

AMENDED

ED MAR 15 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>1 day</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>Jewish Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>5904 Delmar Blvd.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>COOPERMAN</u> Last			4. DATE OF DEATH Month <u>Mar.</u> Day <u>4</u> Year <u>1962</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 type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15 1894</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Garm. Manf.</u>	11. BIRTHPLACE (City and state or country) <u>Roumania</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jos. Cooperman</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel (unk)</u>	14. NAME OF HUSBAND OR WIFE
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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>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Abe Cooperman</u>	Address <u>8608 Frost Ave.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Ruptured cerebral aneurysm</u>	
	DUE TO (c) <u>330x</u>	

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 _____ 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 9-12-44 to 3-4-62 and last saw her alive on 3-4-62  
Death occurred at 6:50 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>McPherson Oigel M.D.</u>	(Degree or title)	22b. ADDRESS <u>100 N. Euclid</u>	22c. DATE SIGNED <u>MAR 6 1962</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>	23b. DATE <u>3/6/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
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24. FUNERAL DIRECTOR <u>Berger Memorial</u>	ADDRESS <u>4715 McPherson Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 6 1962</u>	26. REGISTRAR'S SIGNATURE <u>Neal Smith, M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF  
 ITEM NO.

**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 *Quinn J. Gudburg*  
Licensed Embalmer No. 4229

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.