

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-008040**

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1208**

AMENDED

**FILED FEB 16 1962**

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY-AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
St. Louis		St. Louis				Missouri		St. Louis		University City		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Yes <input type="checkbox"/> No <input type="checkbox"/>									
Jewish Hospital				Yes <input type="checkbox"/> No <input type="checkbox"/>		855 Westgate Ave.				Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. SEX										
First		Middle		Last		Month			Day			Year							
DAVID		FLINK		FLINK		JANUARY			28th			1962							
6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR		Months		Days		Hours		Min.	
White				Unk.		Apt. 92													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY							
Retired				Merchant				Russia				U.S.A.							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE											
Unknown				Unknown				Julia Flink											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address							
Unk.				Unk.				Julia Flink				855 Westgate Ave.							
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) <i>Carcinoma of rectum; fracture of left hip and shoulder; Generalized arterio Sclerosis; suffered when deceased fell in his room at Jewish Hospital on January 26<sup>th</sup> 1962</i>																			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.																			
DUE TO (b) <i>See above</i>																			
DUE TO (c) <i>Accident</i>																			
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.) <i>154X See above</i>															
20c. TIME OF INJURY Hour ? s.m. p.m.		Month, Day, Year 1-26-62		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.) <i>12 Hospital</i>		20f. CITY, TOWN, OR LOCATION <i>St. Louis, Mo.</i>		COUNTY		STATE							
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <i>[Signature]</i>						22b. ADDRESS <i>1300 Clair</i>						22c. DATE SIGNED <i>1-29-62</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)							
Removal		1/29/62		Chesed Shel Emeth Cem.				St. Louis County Missouri											
24. FUNERAL DIRECTOR						ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
HERMAN RINDSKOPF INC. 5216 DELMAR								JAN 29 1962		<i>Loard Smith. M.D.</i>									

**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 John Ketter  
Licensed Embalmer No. 3886

P. O. Address St. Louis

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.