MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

62-020996
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4897

FILED MAY 31 1962

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b: 58 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2006 Shenadoah
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2006 Shenadoah
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First SARAH Middle Last SILBER
4. DATE OF DEATH: Month May Day 14 Year 1962
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Unknown
9. AGE (last birthday): about 79
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
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): Russia
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unk. Berman
13b. MOTHER'S MAIDEN NAME: Unk
14. NAME OF HUSBAND OR WIFE: Louis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Ann Levin Address: 6300 Cabanne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): generalized arteriosclerosis — years
DUE TO (c): 420.1
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-16-47, to 5-14-62 and last saw her alive on 5-2-62
Death occurred at 5 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: M. Norman Orgel (Degree or title) M.D.
22b. ADDRESS: 400 N. Euclid
22c. DATE SIGNED: 5/14/62
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5/15/62
23c. NAME OF CEMETERY OR CREMATORY: Beth Hamedrosh Hagodol
23d. LOCATION (City, town, or county) (State): Ladue, Mo.
24. FUNERAL DIRECTOR: Berger Memorial ADDRESS: 4715 McPherson
25. DATE RECD. BY LOCAL REG.: MAY 14 1962
26. REGISTRAR'S SIGNATURE: Joan Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED	BY AFFIDAVIT OF
1				
2	22	39	2	
3				
4	1			
5	2			
6				
7	2			
8	2			
9				
10				
11				
12	90-0			
13				
	90			

USE BLACK INK OR TYPEWRITER RIBBON

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_____

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.