

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029131

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

318

Primary Registration District No. **1003**

1003

Registrar's No. **7610**

7610

FILED AUG 13 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b		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 <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4459 GRACE AVE				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4459 GRACE AVE				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last SCHACHNER						4. DATE OF DEATH Month AUG Day 2 Year 1962					
5. SEX MALE		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 OCT 19 1874		9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHIPPING CLERK CORNELI SEED CO				10b. KIND OF BUSINESS OR INDUSTRY ST. LOUIS MO.		11. BIRTHPLACE (City and state or country) U-S-A		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME NICK SCHACHNER				13b. MOTHER'S MAIDEN NAME ELIZABETH URBERGER				14. NAME OF HUSBAND OR WIFE SOPHIE SCHACHNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address SOPHIE SCHACHNER 4459 GRACE AVE					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma										INTERVAL BETWEEN ONSET AND DEATH 6 mo	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Carcinoma of Prostate								
DUE TO (c) 177X											
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.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year									
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			
21. I attended the deceased from 2-15-62-8/2/62 last saw her alive on 8-2-62 Death occurred at 6:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Andrew G. Keim, M.D.						22b. ADDRESS 4632 So Grand			22c. DATE SIGNED 8-3-62		
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE AUG. 4 1962		23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK		23d. LOCATION (City, town, or county) ST. LOUIS CO., MO.		(State)			
24. FUNERAL DIRECTOR Thomas Katis 2906 Gravois				25. DATE RECD. BY LOCAL REG. AUG 3 1962		26. REGISTRAR'S SIGNATURE Coal Smith, M.D.					

UNIVERSITY OF MISSISSIPPI

Dr. Klein
4/6 32 & Howard
7/2 3 2000

2304 2/10

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 J. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address 2906 Graciers

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.