

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029165

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7383

FILED AUG 6 1962

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		c. CITY OR TOWN <u>University City</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 Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8662 Delmar Blvd.</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>ABRAHAM</u> Middle <u>SHAMPAINE</u> Last <u>SHAMPAINE</u>			4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1962</u>			5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>UNK</u>		9. AGE (last birthday) <u>Abt. 75</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Furniture</u>			11. BIRTHPLACE (City and state or country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Joseph Shampaine</u>				13b. MOTHER'S MAIDEN NAME <u>Yetta Bogolowitz</u>				14. NAME OF HUSBAND OR WIFE <u>Ida</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk</u>				16. SOCIAL SECURITY NO. <u>Unk</u>				17. INFORMANT <u>Mrs. A. Shampaine-8662 Delmar Blvd.</u>				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u>												INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>							
DUE TO (b) <u>Cerebra hemorrhage</u>												<u>6 weeks</u>							
DUE TO (c) <u>Arteriosclerosis</u> <u>331X</u>												<u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>										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 <u> </u> a.m. <u> </u> p.m. <u> </u>		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 <u>1956</u> to <u>date</u> and last saw him alive on <u>July 26, 1962</u> Death occurred at <u>1 1/2 m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>Bernard Hulbert, M.D.</u>						22b. ADDRESS <u>8112 Delmar</u>			22c. DATE SIGNED <u>July 27/62</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/29/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sinai Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>												
24. FUNERAL DIRECTOR <u>Herman Rindskopf, Inc. 5216 Delmar</u>				25. DATE RECD. BY LOCAL REG. <u>JUL 27 1962</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>													

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. 31296

P. O. Address St Louis, Mo

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.