

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036607

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8753 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

2 219

3

4 0

5 1

6

7 0

8 1

9

10

11 000

12 740

13

74

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION BY AFFIDAVIT OF

FILED SEP 17 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>St. Louis</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>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3658 W. Pine</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Sidney J. PUSTER</u>			4. DATE OF DEATH Month Day Year <u>Sept. 9, 1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</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>5-15-82</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>George Puster</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Fritshle</u>	
14. NAME OF HUSBAND OR WIFE <u>Clotilde A. Puster</u>		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>Mrs. Clotilde Puster, 3658 W. Pine Blvd.</u>		17. ADDRESS		17. 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) Arteriosclerotic heart disease

CONDITIONS OF ANY WHICH GAVE RISE TO CAUSE (a), (b), OR (c) UNDERLYING CAUSE (b) Pat. of hip fracture for

OTHER CAUSE (c) fractured rt. hip 9040-21

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Relab. Bronch. Pneumonia

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell in his home</u>
---	--	---

20c. TIME OF INJURY Hour a.m. p.m. <u>8/29/62</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	COUNTY	STATE
---	---	--	--------	-------

21. I attended the deceased from 8/29/62 to 9/9/62 and last saw her alive on 9/9/62
Death occurred at 9/9/62 - 9:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Typed or title) <u>Maunie B. Roche, M.D.</u>	22b. ADDRESS <u>3720 Washington Ave.</u>	22c. DATE SIGNED <u>9/9/62</u>
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-11-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Arthur J. Kennell</u>	ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 10 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	--------------------------------------	--	--

DR ~~MAURICE~~ ROACHE

3720 Washington

Coroner D.C.

12:30

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 *[Signature]*

Licensed Embalmer No. 4699
P. O. Address 3840 Lendell

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.