

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037212

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2618

**FILED SEP 20 1962**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>DOA.</b>	c. CITY OR TOWN <b>Webster Groves</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>County Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>718 Catalpa</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEFFREY BURKE SINGER</b>			4. DATE OF DEATH Month Day Year <b>Sept. 8, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/1957</b>
9. AGE (last birthday) <b>4</b>		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) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>Shreveport, La.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Stephen Singer</b>	
14. MOTHER'S MAIDEN NAME <b>Judithe White</b>		15. NAME OF HUSBAND OR WIFE <b>Stephen Singer 1127 N. McKnight, Memphis Tenn.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple trauma</b>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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 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.) <b>Passenger in car involved in collision with another vehicle</b>	
20c. TIME OF INJURY Hour Month, Day, Year <b>6:30 XOX p.m. 9/8/62</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <b>St. Louis Missouri</b>		COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Raymond W. Hair</i> Coroner		22b. ADDRESS <b>Clayton, Missouri</b>	22c. DATE SIGNED <b>9/12/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>	23b. DATE <b>9/10/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Ararat</b>	23d. LOCATION (City, town, or county) (State) <b>Pine Lawn, N.Y.</b>
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 McPherson</b>		25. DATE RECD. BY LOCAL REG. <b>9-10-62</b>	26. REGISTRAR'S SIGNATURE <i>John B. Mumphy</i>

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

14002  
24007

3  
4 0  
5 0  
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7 1  
8 2  
9 X  
10 X  
11400  
1292-3  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

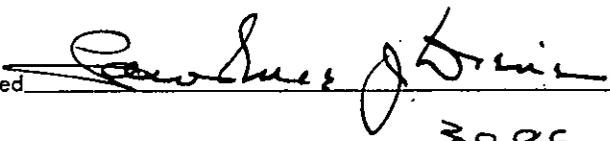
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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.