

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-003975

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **770** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 9 1 1963

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		d. STREET ADDRESS (If outside, give location)		Reside on Farm		
St. Louis		St. Louis		80 yrs.	Mo.				St. Louis		310 Belt		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION		Jewish Hosp.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year				
IDA					PIAN	Jan. 23, 1963									
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
Female		Cauc.				10/2/82		80		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of year, if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
housewife								St. Louis, Mo.				USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
Frederick Frank				Annie Goldberg				William							
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)				17. INFORMANT				Address							
No								Iana Oakley 5370 Pershing							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)												10 Days			
DUE TO (b)												years			
DUE TO (c)												years			
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			
Arteriosclerosis obliterans with gangrene right foot												12 days			
												Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <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 Oct. 6, 1959 to Jan. 23, 1963 and last saw her alive on Jan. 23, 1963															
Death occurred at 8:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED			
Jos. M. Orenstein, M.D.						4500 Olive St						1/23/63			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				23e. (State)			
Burial		1/25/63		United Hebrew Temple Cem.				University City Mo.							
24. FUNERAL DIRECTOR		ADDRESS		25. DATE FILED BY LOCAL REG.		26. REGISTRAR'S SIGNATURE									
Berger Memorial		14715 McPherson		JAN 24 1963		Joan Smith, M.D.									

USE BLACK INK OR TYPEWRITER RIBBON

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DEPARTMENT OF HEALTH

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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 *Lawrence J. Dean*

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.