

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-004414

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 117

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 25 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Florissant</u> Length of stay in 1b <u>2 1/2</u> years c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3355 Rockingham Dr.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Florissant</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>3355 Rockingham Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED: First <u>LEWIS</u> Middle <u>MAUPIN</u> Last <u>CHORN</u>			4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1963</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>8/5/82</u>	9. AGE (last birthday) <u>80</u>	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) <u>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Live Stock Dealer</u>	11. BIRTHPLACE (City and state or country) <u>Howard County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James D. Chorn</u>	13b. MOTHER'S MAIDEN NAME <u>Mattie Maupin</u>	14. NAME OF HUSBAND OR WIFE <u>Lutie Chorn</u>
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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. <u>7</u>	17. INFORMANT Address <u>Florissant, Mo.</u> <u>Mrs. Lutie Chorn, 3355 Rockingham Dr.</u>
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18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>18 yrs</u>
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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
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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 January 16, 1961 to January 13, 1963 and last saw her alive on January 2, 1963
 Death occurred at 3 o'clock a. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph Egan, M.D.</u>	22b. ADDRESS <u>390 W. St. Anthony Florissant, Mo.</u>	22c. DATE SIGNED <u>1/13/63</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1/14/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fayette City Cemetery</u>	23d. LOCATION (City, town, or county) <u>Fayette, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Louis N. Bopp, Inc., Kirkwood, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-13-63</u>	26. REGISTRAR'S SIGNATURE <u>John W. Murphy, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 14013
 24013
 3
 4 0
 5 1
 6
 7 0
 8 2
 9 332X
 10
 11
 12 90-0
 13
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Francis J. Myland Jr.

Licensed Embalmer No. 4517

P. O. Address Richard, 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.