

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-008448

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 1624

STATE FILE NUMBER

FILED FEB 19 1963

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
1						
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12						
13						
90.	SHOULD READ	ITEM NO.				

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY				a. STATE <u>Mo</u>		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b <u>40 YRS</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>3408^a Wyoming</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3408^a Wyoming</u>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)			First <u>JOHN</u> Middle <u>CHRISTEL</u> Last <u>CHRISTEL</u>			4. DATE OF DEATH	
						Month <u>2</u> Day <u>19</u> Year <u>1963</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12/5/87</u>	9. AGE (last birthday) <u>75</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>BUTCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MEAT MARKET</u>		11. BIRTHPLACE (City and state or country) <u>ROMANIA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John CHRISTEL</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			14. NAME OF HUSBAND OR WIFE <u>ANNA CHRISTEL</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>				17. INFORMANT <u>ANNA CHRISTEL</u>		Address <u>3408^a Wyoming ST. LOUIS Mo</u>	
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>Arteriosclerotic heart dis</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b) <u>4200</u>			
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 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		Jan 2 3:15 P. m.		and last saw her him alive on		2/13/63	
Death occurred at: <u>3:15 P. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Ralph Berg MD</u> (Degree or title)				22b. ADDRESS <u>3203 S Grand</u>		22c. DATE SIGNED <u>2/14/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>2/16/63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul</u>		23d. LOCATION (city, town, or county) (State) <u>7000 Broadway St Louis Mo</u>	
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>FEB 14 1963</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

ALN Berg
PR 3-7857

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 *Cooley Thompson*
Licensed Embalmer No. 4861

P. O. Address *H. Lane 19, 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.