

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021933

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5017

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY ST. LOUIS, MO.
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Length of stay in 1b
c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP Inside Limits Yes No d. STREET ADDRESS (If outside, give location) UNKNOW N Reside on Farm Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN ST. LOUIS Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) UNKNOW N Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last JOE MARKUS 4. DATE OF DEATH 5-4-63 Month Day Year

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH FEB 19 1919 44 9. AGE (last birthday) 44 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 11. BIRTHPLACE (City and state or country) ST LOUIS MO. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME JOSEPH MARKUS 13b. MOTHER'S MAIDEN NAME CATHERINE BARTOS 14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) NO 17. INFORMANT Address ROSE ZIMMERMAN ARNOLD MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction Suspected
DUE TO (b) 4.2 D.1
DUE TO (c)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. Progressive Heart muscle atrophy
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 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 Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 4-29-63 to 5-4-63 and last saw her/him alive on 5-4-63
Death occurred at 12:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas J. Kelly MD 22b. ADDRESS 1515 Lafayette ave 22c. DATE SIGNED 5-4-63 (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 5-18-63 23c. NAME OF CEMETERY OR CREMATORY St. Matthews 23d. LOCATION (City, town, or county) (State) St. Louis Mo.

24. FUNERAL DIRECTOR ADDRESS Thomas Kutai 2906 Gravois 25. DATE RECD. BY LOCAL REG. MAY 9 1963 26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

RUZON

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 *J. A. Hemphrey*

Licensed Embalmer No. 4772

P. O. Address 2906 Graves'

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.