

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-021990
6056 STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUN 13 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		c. CITY OR TOWN University City	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 740 Leland	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) NAT M. MOLOS			4. DATE OF DEATH June 6, 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/15/1900	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Office Equipment	11. BIRTHPLACE (City and state or country) Russia	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Sam Molos		13b. MOTHER'S MAIDEN NAME Goldie Unknown		14. NAME OF HUSBAND OR WIFE Fannie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Fannie Molos 740 Leland		

18. CAUSE OF DEATH (Enter only one cause of death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 7 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Arteriosclerotic Heart Disease		5 years
DUE TO (c) 420.0		
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 1945 to Present and last saw him alive on 6/6/63 Death occurred at 1 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or title) Jessie M. Volant MD		22b. ADDRESS 4409 W. Olive		22c. DATE SIGNED 6/7/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/9/1963	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha	23d. LOCATION (City, town, or county) (State) University City, Missouri		
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson Avenue		25. DATE RECD. BY LOCAL REG. JUN 8 1963	REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

VS:300 Rev. 4/59
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 64

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF OHIO

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. Davis*

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.