

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022693

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1487

FILED MAY 27 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

- 1 4002
- 2 4006
- 3 2
- 4 1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>810 Yale</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle Last <b>MINKIN</b>			4. DATE OF DEATH Month <b>5</b> Day <b>5</b> Year <b>63</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/24/1913</b>
9. AGE (last birthday) <b>49</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Educator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Harry Cohen</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Tabachnick</b>		14. NAME OF HUSBAND OR WIFE <b>---</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No None</b>		16. SOCIAL SECURITY NO. <b>6</b>	17. INFORMANT Address <b>Sarah Cohen 810 Yale</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Splenic artery aneurysm</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bilateral Pulmonary atelectasis</b>			PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>5-5-63</b> to <b>5-5-63</b> and last saw her/him alive on <b>5-5-63</b> . Death occurred at <b>11:20 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Paul W. Schapa M.D.</b>		22b. ADDRESS <b>601 So. Brentwood Clayton Mo</b>	22c. DATE SIGNED <b>5-6-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/7/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>	23d. LOCATION (City, town, county) (State) <b>University City, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson Avenue</b>		25. DATE RECD. BY LOCAL REG. <b>5-7-63</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>

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

*Quis G. Juding*  
Licensed Embalmer No. 4229

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.**