

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025903

318 1003

6972

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JUL 12 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, or if institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 mos</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>Jewish Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>702 Syracuse Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>SAM (aka SAMUEL)</b> Middle <b>Goldstein</b> Last <b>GOLDSTEIN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1963</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>cauc.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	11. BIRTHPLACE (City and state or country) <b>Memphis, Tenn</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Jacob Goldstein</b>	
13b. MOTHER'S MAIDEN NAME <b>Clara (unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Fannie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harry Goldstein</b>		Address <b>702 Syracuse</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>Bronchopneumonia</b> DUE TO (b) <b>Bronchogenic Carcinoma, metastatic</b> DUE TO (c) <b>1621</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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>6/4/63</b> to <b>7/4/63</b> and last saw her <sup>her</sup> alive on <b>7/3/63</b> Death occurred at <b>10<sup>35</sup> A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Alvin S. Wenzel, MD</b>		22b. ADDRESS <b>8112 Delmar</b>	22c. DATE SIGNED <b>7/4/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>7-5-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chevra Kadisha Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 5 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>

**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 *Edmund J. Bill*

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.