

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030629

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

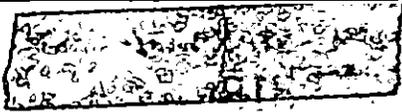
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7052 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB  
 AMENDED

VS 300 Rev. 4/59	DATE AMENDED		AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
1								
2		4003						
3								
4		0						
5		3						
6								
7		0						
8		1						
9								
10								
11								
12		92-3						
13								
	91							

USE BLACK INK OR TYPEWRITER RIBBON

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 <u>St. Louis</u>		a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA City Hospital</u>		c. CITY OR TOWN <u>Clayton (5)</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>828 Audubon</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WEISS</u> Last <u>WEISS</u>			4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1914</u>
9. AGE (last birthday) <u>49</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Rep.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garment Mfr.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>David Weiss</u>		13b. MOTHER'S MAIDEN NAME <u>Jennie Drezner</u>	
14. NAME OF HUSBAND OR WIFE <u>(unk)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Morris Weiss</u>		Address <u>828 Audubon</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>Coronary occlusion;</u> <u>Pulmonary edema.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>522X</u> DUE TO (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		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 <u>  </u> STATE <u>  </u>	
21. I attended the deceased from <u>                    </u> to <u>                    </u> and last saw her/him alive on <u>                    </u> . Death occurred at <u>5:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>                    </u> (Degree or title)		22b. ADDRESS <u>1900 Clara</u>	
22c. DATE SIGNED <u>7-6-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>7-7-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chebra Kadisha Cem.</u>	
23d. LOCATION (City, town, or county) <u>University City, Mo.</u>		(State)	
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 8 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Roan Smith. M.D.</u>			



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**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. Brown*

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.