

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033914

8744

STATE FILE NUMBER

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

FILED SEP 6 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 Mo.		a. STATE Mo. b. COUNTY St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hos'p		c. CITY OR TOWN Ladue	
Length of stay in 1b 8 months		d. STREET ADDRESS (If outside, give location) 401 South Warson	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Claire	Middle MAYER	Last Mellitz	Month 8	Day 29	Year 63
5. SEX Female	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/29/13	9. AGE (last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Louis Mayer		13b. MOTHER'S MAIDEN NAME Olga Aronson	
14. NAME OF HUSBAND OR WIFE Bernard Mellitz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Bernard Mellitz		Address 401 S. Warson Rd			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchopneumonia		5 days
DUE TO (b) 491x		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
CEREBRAL ATROPHY SECONDARY TO ANEURYSM OF BRAIN ARTERY		
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 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 2/21/46 to 8/29/63 and last saw her alive on 8/28/1963	
Death occurred at 2:30 AM on the date stated above, and to the best of my knowledge, from the causes stated:	
22a. SIGNATURE Shirley Ann New (Degree or title)	22b. ADDRESS 634 N. GRAND
22c. DATE SIGNED 8/29/63 (State)	

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8/30/63	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai	23d. LOCATION (City, town, or county) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Mayer ADDRESS 4356 Lindell Blvd		25. DATE RECD. BY LOCAL REG. AUG 29 1963	26. REGISTRAR'S SIGNATURE Loed Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 VS 300 Rev. 4/59
 1
 24029
 3
 4 1
 5 1
 6
 7 0
 8 1
 9
 10
 11
 12 52-0
 13
 52
 USE BLACK INK OR TYPEWRITER RIBBON
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF DOCUMENT

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. Wm. Dunbley

Licensed Embalmer No. 3653

P. O. Address St. Louis, Mo.

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.