

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033948

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8325

FILED AUG 29 1963

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF DOCUMENT

| | | | | | | | | | |
|--|--|---|---|--|---|--|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 2 days | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | c. CITY OR TOWN University City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hosp. | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 958 Briarwood | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HYMAN MORROS | | | 4. DATE OF DEATH Month Day Year Aug. 15, 1963 | | | 5. SEX Male | | 6. COLOR OR RACE Cauc. | |
| 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Unknown | | 9. AGE (last birthday) About 82 | | 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) Baker | | | 10b. KIND OF BUSINESS OR INDUSTRY Bakery Shop | | 11. BIRTHPLACE (City and state or country) Poland | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME (unk) Morros | | | 13b. MOTHER'S MAIDEN NAME Unk | | | 14. NAME OF HUSBAND OR WIFE Mary | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No | | | | 17. INFORMANT Meyer Morros 958 Briarwood | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary</i> DUE TO (b) <i>Heart exhausted</i> DUE TO (c) <i>931.9 = 4/6</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 1/2</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Ch. Bronch Syndrome</i> | | | | | | 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 Month, Day, Year a.m. p.m. | | 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 35 | | COUNTY STATE | |
| 21. I attended the deceased from 1961 to Aug '63 and last saw her/him alive on 8/14/63 | | | | Death occurred at 730 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <i>M. Kinsman M.D.</i> | | | | 22b. ADDRESS 1005 My Dear | | | 22c. DATE SIGNED 8/15/63 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/16/1963 | | 23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth | | 23d. LOCATION (City, town, or county) University City, Mo. | | | |
| 24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson | | | | 25. DATE RECD. BY LOCAL REG. AUG 16 1963 | | 26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i> | | | |

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

[Handwritten Signature]

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.

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