

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034391

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2473

FILED AUG 19 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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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 <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves, Mo.</u>		Length of stay in 1b <u>14 years</u>		c. CITY OR TOWN <u>Webster Groves</u> Inside Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>602 Fairview</u>			d. STREET ADDRESS (If outside, give location) <u>602 Fairview</u> Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>A/K/A First Rosa Glazer Middle Last Rose (n.m.i.) Glazier</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-74</u>	9. AGE (last birthday) <u>89</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.s</u>	
13a. FATHER'S NAME <u>August Schultz</u>			13b. MOTHER'S MAIDEN NAME <u>Catherine Wieghorst</u>		14. NAME OF HUSBAND OR WIFE (Dec.) <u>Gustave Glazier (Dec.)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Miss Helen Glazier 602 Fairview</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>Acute Pulmonary Edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> <u>7.5 yrs</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u> <u>10 year</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hematemesis - G.I. Bleeding</u>					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 <u>1956</u> to <u>8-1-63</u> and last saw her <u>live</u> on <u>8-1-63</u> Death occurred at <u>10:00 p</u> m on the date stated above, and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE (Degree or title) <u>Grant J. ... MD</u>			22b. ADDRESS <u>7961 Big Bend Webster Groves</u>		22c. DATE SIGNED <u>8-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-5-63</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethany Cemetery</u>	
			23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa</u>			25. DATE RECD. BY LOCAL REG. <u>8-5-63</u>		26. REGISTRAR'S SIGNATURE <u>John Murphy MD</u>

Dr. Grant Izmirlian
7961 Big Bend
MO. 1-8763

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 John S. Pennehy

Licensed Embalmer No. 4194
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.

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