

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038077

9699

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED OCT 10 1963

VS 300  
Rev. 4/59

1

2 40063

3

4 0

5 2

6

7 2

8 2

9

10

11

12 64-0

13

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		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>		c. CITY OR TOWN <b>University City</b>	
Length of stay in 1b <b>2 wks.</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 Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>7110 Dartmouth</b>	
Inside Limits Yes <input checked="" 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 <b>MEYER</b> Middle <b>SUBOVITZ</b> Last <b>SUBOVITZ</b>			Month <b>Sept.</b> Day <b>27,</b> Year <b>1963</b>
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
<b>Male</b>	<b>Cauc.</b>		<b>ab. 1892</b>
		9. AGE (last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
		<b>about 71</b>	<b>Merchant</b>
		11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
		<b>Russia</b>	<b>USA</b>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
<b>Unk. Subovitz</b>		<b>Unk.</b>	<b>Betty</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of)		17. INFORMANT	
<b>No</b>		Address <b>Herbert Subovitz 7110 Dartmouth</b>	
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) <b>Generalized arteriosclerosis</b>			<b>5 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) <b>4500</b>			
DUE TO (c)			
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 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>July 1950</b> to <b>Sept 27, 1963</b> and last saw <sup>her</sup> him alive on <b>Sept 27, 1963</b>		Death occurred at <b>7:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title)		22b. ADDRESS	22c. DATE SIGNED
<b>Paul D. Selovitz M.D.</b>		<b>100 No. Euclid St. Louis 8 Mo</b>	<b>9.28.63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>rem.</b>	<b>9/29/1963</b>	<b>Chesed Shel Meth</b>	<b>University City, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
<b>Berger Memorial 8715 Mc Pherson</b>		<b>SEP 30 1963</b>	<b>Paul Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

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

*Mat Embalmer*  
Signed \_\_\_\_\_  
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.