

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038273

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2740

FILED SEP 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 4006
2 4006
3
4 1
5 1
6
7 0
8 2
9 4201
10
11
12 90-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | |
|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN University City | | Length of stay in 1b 12 yrs. | | c. CITY OR TOWN University City | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1085 North & South Rd. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1085 North & South Rd. | |
| 3. NAME OF DECEASED (Type or print) ETHEL | | First ETHEL | | Middle FEIGENBAUM | |
| 4. DATE OF DEATH Sept. 2, 1963 | | Month Sept. Day 2 Year 1963 | | 5. SEX Female | |
| 6. COLOR OR RACE auc. | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 4-20-1908 | |
| 9. AGE (last birthday) 55 | | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | |
| 13a. FATHER'S NAME Samuel Cooperman | | 13b. MOTHER'S MAIDEN NAME Dora Schwartz | | 14. NAME OF HUSBAND OR WIFE Hyman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hyman Feigenbaum 1085 No. & So. Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 10 YEARS | |
| 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 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 1954 to 9/2/1963 and last saw her alive on 8/26/63 . Death occurred at 12:37 AM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE David Feigenbaum M.D. (Degree or title) | | 22b. ADDRESS 150 N. MERAMEC, CLAYTON, MO. | | 22c. DATE SIGNED 9/2/63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) bur. | | 23b. DATE 9/11/1963 | | 23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol | |
| 23d. LOCATION (City, town, or county) Ladue, Mo. | | 24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson | | 25. DATE RECD. BY LOCAL REG. 9-3-63 | |
| 26. REGISTRAR'S SIGNATURE John B. Muffley M.D. | | | | | |

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

Ernie J. Quilburg

Licensed Embalmer No. 4229

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.