

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-038511

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2889

STATE FILE NUMBER

VS 300
Rev. 4/59

1 4002
2 4002
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4 0
5 1
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7 3
8 3
9 4200
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12 90-0
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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>Clayton (5)</u>		Length of stay in lb <u>20 yrs</u>	c. CITY OR TOWN <u>Clayton (5)</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>828 Audubon Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>828 Audubon Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>L.</u> Last <u>WEISS</u>			4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1963</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-22-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ladies Garments</u>	9. AGE (last birthday) <u>59</u>
11. BIRTHPLACE (City and state or country) <u>Warsaw, Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>David Weiss</u>		13b. MOTHER'S MAIDEN NAME <u>Jennie Drezner</u>	
14. NAME OF HUSBAND OR WIFE <u>Fannie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>Malcolm Weiss</u> Address <u>1317 Monaco Ct. (41)</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> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
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 _____ 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>1946</u> to <u>9-16-63</u> last saw him alive on <u>9-16-63</u> Death occurred at <u>10:45 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Melvin B. Kinsten MD.</u> (Degree or title)		22b. ADDRESS <u>St Louis 5, Mo.</u>	
22c. DATE SIGNED <u>9-17-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-18-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chebra Kadisha Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u>		25. DATE RECD. BY LOCAL REG. <u>9-17-63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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 *Lawrence J. Davis*

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.