

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042401

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3249

FILED OCT 30 1963

DO NOT WRITE ON THIS STUB
- AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	ITEM NO.	SHOULD READ
1 <u>4005</u>								
2 <u>24011</u>								
3								
4 <u>0</u>								
5 <u>1</u>								
6								
7 <u>0</u>								
8 <u>1</u>								
9 <u>9923.9</u>								
10 <u>46</u>								
11 <u>400</u>								
12 <u>460</u>								
13								

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in 1b 2 hrs.	c. CITY OR TOWN Brentwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 878 1/2 Bridgeport Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle V. H. Last POSCH			4. DATE OF DEATH Month Oct. Day 22 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-19-1886
9. AGE (last birthday) 76		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) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Own account	11. BIRTHPLACE (City and state or country) Festus, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Herman Posch	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Ethyl Z. Cox Posch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethyl Z. Posch,		Address above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction, terminal ileum			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Phytobezor.			1 day
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus			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 checked="" type="checkbox"/> NO <input 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.	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>7/23/36</u> to <u>10/22/63</u> and last saw him alive on <u>10/22/63</u> Death occurred at <u>7:35</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Ch Beckman MD</i> (Degree or title)		22b. ADDRESS 2615 Brentwood Blvd. S. St. Louis 44, Mo.	22c. DATE SIGNED 10-23-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-25-1963	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo. (State)
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 10-23-63	24. REGISTRAR'S SIGNATURE <i>John C. Murphy MD</i>

USE BLACK INK OR TYPEWRITER RIBBON

10110-011

CHBockelman MD

WO 2-1907

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 H E Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.