

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042434

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3122

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300 Rev. 4/59	DATE AMENDED	
1 <u>4000</u>	2	
2 <u>4000</u>	3	
3	4	
4 <u>1</u>	5	
5 <u>2</u>	6	
6	7	
7 <u>0</u>	8	
8 <u>2</u>	9	
9 <u>4/201</u>	10	
10	11	
11	12	
12 <u>90-2</u>	13	
13		

FILED OCT 30 1963

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>Merlywood</u>		Length of stay in 1b <u>55 yrs</u>	c. CITY OR TOWN <u>Merlywood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5628 Willard</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5628 Willard</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Smith</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1963</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</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>11/1/1878</u>
9. AGE (last birthday) <u>84</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>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Carl Strauss</u>	
14. MOTHER'S MAIDEN NAME <u>Louisa Bollinger</u>		15. NAME OF HUSBAND OR WIFE <u>Joseph A.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>_____</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>coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
DUE TO (b) <u>arterio sclerosis</u>			
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 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"/>		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>January 1963</u> to <u>October 11, 1963</u> and last saw her alive on <u>October 11, 1963 8:40 pm</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Paul Rosenberg, D.O.</u>		22b. ADDRESS <u>9302 Gravois</u>	22c. DATE SIGNED <u>10/12/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>10/14/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons</u>		ADDRESS <u>7027 Gravois</u>	25. DATE RECD. BY LOCAL REG. <u>10-12-63</u>
			26. REGISTRAR'S SIGNATURE <u>John L Ziegenhein</u>

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF SHOULD READ

MEDICAL CERTIFICATION BY AFFIDAVIT OF DOCUMENT

111810-1118

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 E. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravois

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.