

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 290 Primary Registration District No. 5995 Registrar's No. 156 **63-044990**

FILED DEC 10 1963

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Bronx	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ft. Leonard Wood, Mo.		Length of stay in 1b 1 mo.	c. CITY OR TOWN New York Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 587 Beck Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ismael G. Ortiz			4. DATE OF DEATH Month Day Year Nov 27 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (last birthday) 17 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11a. BIRTHPLACE (City and state or country) Puerto Rico		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Ismael G. Ortiz		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Sept-Oct 1963	
16. SOCIAL SECURITY NO.		17. INFORMANT 587 Beck Street Ismael G. Ortiz/F, Bronx 55 New York	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis			INTERVAL BETWEEN ONSET AND DEATH 20 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 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. 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 US Army Hospital Ft. Leonard Wood, Missouri		COUNTY STATE
21. I attended the deceased from 7 Nov 1963 to 27 Nov 1963 and last saw him alive on 27 Nov 1963 Death occurred at 11:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Julian C. Wallace</i> JULIAN C. WALLACE, Capt., MC		22b. ADDRESS US Army Hospital Ft. Leonard Wood, Missouri	22c. DATE SIGNED 28 Nov 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/29/1963	23c. NAME OF CEMETERY OR CREMATORY UNKNOWN	23d. LOCATION (City, town, or county) (State) Long Island New York
24. FUNERAL DIRECTOR <i>Mass-Williams</i> Mass-Williams	ADDRESS Waynesville, Mo	25. DATE RECD. BY LOCAL REG. 11-29-63	26. REGISTRAR'S SIGNATURE <i>Julian C. Wallace</i>

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 Clarence J. Moss

Licensed Embalmer No. 4896

P. O. Address Waynesville, Mo.

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.