

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11772-63-049378  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11772

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN |  | Length of stay in 1b  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE |  | b. COUNTY  |  | c. CITY OR TOWN  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |  |  |
|   |  | <u>St. Louis</u>  |  |   |  | <u>Mo.</u>  |  |  |  | <u>St. Louis</u>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | d. STREET ADDRESS (If outside, give location)   |  |  |  |  |  |   |  |  |  |
| <u>E/R To City Hospital</u>   |  |   |  |   |  | <u>421 N. Broadway</u><br><u>St. Regis Hotel</u>  |  |  |  |  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |   |  |   |  | 4. DATE OF DEATH  |  |  |  |  |  |   |  |  |  |
| First   |  | Middle  |  | Last  |  | Month   |  | Day  |  | Year   |  |   |  |  |  |
| <u>Louise</u>   |  |   |  | <u>Donsky</u>   |  | <u>Nov</u>  |  | <u>28</u>  |  | <u>1963</u>  |  |   |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE  |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  | 9. AGE (last birthday)   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HR  |  |  |  |
| <u>Female</u>   |  | <u>Cau.</u>   |  |   |  | <u>7-14-91</u>  |  | <u>72</u>  |  | Months   |  | Days  |  |  |  |
|   |  |   |  |   |  |   |  |  |  | Hours  |  | Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                       |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (City and state or country)   |  |  |  | 12. CITIZEN OF WHAT COUNTRY   |  |  |  |
| <u>House Wife</u>   |  |   |  | <u>Home</u>   |  |   |  | <u>Alaska</u>  |  |  |  | <u>U.S.A.</u>   |  |  |  |
| 13a. FATHER'S NAME  |  |   |  | 13b. MOTHER'S MAIDEN NAME   |  |   |  | 14. NAME OF HUSBAND OR WIFE  |  |  |  |   |  |  |  |
| <u>Nicholas Free</u>  |  |   |  | <u>Maria Rebruary</u>   |  |   |  | <u>Alexander Donsky</u>  |  |  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)                          |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |  |  |  |  |   |  |  |  |
| <u>No</u>   |  |   |  | <u>Unknown</u>  |  | <u>Alexander Donsky St. Regis Hotel</u>   |  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  |   |  |   |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| <u>Atherosclerotic Heart Disease</u>  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| DUE TO (b)  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| <u>Generalized Atherosclerosis</u>  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| DUE TO (c)  |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| <u>4200</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 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 _____ to _____ and last saw her/him alive on _____   |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.                      |  |   |  |   |  |   |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE (Degree or title)  |  |   |  |   |  | 22b. ADDRESS  |  |  |  |  |  | 22c. DATE SIGNED (State)  |  |  |  |
| <u>Joseph M. Smith</u>  |  |   |  |   |  | <u>1300 Clark</u>   |  |  |  |  |  | <u>11-29-63</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City, town, or county)  |  |  |  |   |  |  |  |
| <u>Cremation</u>  |  | <u>11-30-63</u>   |  | <u>Missouri Crematory</u>   |  |   |  | <u>St. Louis, Missouri</u>   |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |   |  |   |  | 25. DATE RECD. BY LOCAL REG.  |  | 26. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |
| <u>McLaughlin 2301 Lafayette Ave. St. Louis, Mo. 63104</u>  |  |   |  |   |  | <u>NOV 29 1963</u>  |  | <u>Paul Smith M.D.</u>   |  |  |  |   |  |  |  |

USE BLACK INK OR TYPEWRITER RIBBON

401 W. Broadway

**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,

*NOT*

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *James R. Chapman*

Licensed Embalmer No. 4550

P. O. Address St. Louis, 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.