

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049743

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12743** STATE FILE NUMBER

FILED JAN 6 1964

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>30 Yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>1720a Nicholson Pl.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ARTHUR MASCHKER</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>23,</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/95</b>
9. AGE (last birthday) <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>E. St. Louis, Ill.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Unk. Maschker</b>	
13b. MOTHER'S MAIDEN NAME <b>Minnie (Unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Vera Maschker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>Yes WW1</b>		16. SOCIAL SECURITY NO. <span style="border: 1px solid black; padding: 2px;">                    </span>	
17. INFORMANT <b>Vera Maschker, 1720a Nicholson Pl.</b>		Address <b>St. Louis, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>4201</b> DUE TO (c) <b>4201</b>			INTERVAL BETWEEN ONSET AND DEATH
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 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 <b>          </b> s.m. <b>          </b> p.m. <b>          </b>	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 <b>12/18/63</b> to <b>12/23/63</b> and last saw her/him alive on <b>12/23/63</b> Death occurred at <b>7A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not use title) <b>Donald K. Back M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE</b>	22c. DATE SIGNED <b>12/23/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12/26/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>	23d. LOCATION (City, town, or county) (State) <b>Jeff. Brk's., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>McLaughlin, 2301 Lafayette Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 24 1963</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>

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AMENDED  
 DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

Donald K. Back, M.D.  
 USE BLACK INK  
 OR  
 TYPEWRITER RIBBON

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 James R. Chapman

Licensed Embalmer No. 4552

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. D. J. Lewis

If this body is not embalmed, fact should be so stated above.