

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049924

STATE FILE NUMBER

Registration District No. 318

Primary Registration District 1003

Registrar's No. 12728

FILED JAN 6 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY - - -			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY - - -			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Length of stay in 1b <u>14 days</u>		c. CITY OR TOWN <u>St. Louis</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>Jewish Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6137 Crescent</u>	
3. NAME OF DECEASED (Type or print) First <u>Mitchell</u> Middle <u>Charles</u> Last <u>Scherzinger</u>			4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1963</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1917</u>	9. AGE (last birthday) <u>45</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>engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Moloney Electric</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Mitchell C. Scherzinger Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Helen K. Finn</u>		14. NAME OF HUSBAND OR WIFE <u>Jeanne M. Scherzinger</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>                    </u>		17. INFORMANT Address <u>Mrs. Jeanne Scherzinger 6137 Crescent</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>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>4201</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 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 <u>          </u> Month, Day, Year <u>          </u> a.m. <u>          </u> p.m. <u>          </u>		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>12-14-63</u> to <u>12-22-63</u> and last saw her alive on <u>12-21-63</u> Death occurred at <u>4:15 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>Elizabeth A. Stoddard M.D.</u>			22b. ADDRESS <u>Jewish Hospital St. Louis</u>		22c. DATE SIGNED <u>12-23-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-26-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>HOFFMEISTER COLONIAL MORTUARY 6464 Chippewa</u>			25. DATE RECD. BY LOCAL REG. <u>DEC 23 1963</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>		

AS 002.7-07-08

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 Lisa C. Seanson

Licensed Embalmer No. 4764

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.

Dr. Franz Steinberg  
216 S. Kingshighway  
FO. 7-8080