

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

0051091

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

317 Primary Registration District No. 541 Registrar's No. 4047  
FILED JAN 16 1964

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

VS 300 Rev. 4/59

1 4002

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>ST. LOUIS</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CLAYTON</b>		Length of stay in 1b	c. CITY OR TOWN <b>OLIVETTE</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 County Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b># 1 Ridgeway</b>	
3. NAME OF DECEASED (Type or print) First <b>MARJORIE</b> Middle <b>ROSE</b> Last <b>DEITCHMAN</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>31st</b> Year <b>1963</b>		
5. SEX <b>Female</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>3/20/23</b>	9. AGE (last birthday) <b>40</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Percy Fusfeld</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Lippkowitz</b>		14. NAME OF HUSBAND OR WIFE <b>Robt. B. Deitchman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dr. Robt. B. Deitchman 1 Ridgeway</b>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b>					<b>5 months</b>
DUE TO (b) <b>Adenocarcinoma of the Ovary, Metastatic</b>					<b>7 months</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) <b>None</b>				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.) <b>No injury</b>			
20c. TIME OF INJURY Hour a.m. p.m.	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>1961</b> to <b>Dec. 31, 1963</b> and last saw him alive <b>Dec. 31, 1963</b> Death occurred at <b>4 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>David M. Lieberman, M.D.</b> (Degree or title)			22b. ADDRESS <b>4511 Forest Park, St. Louis, Mo.</b>		22c. DATE SIGNED <b>1 Jan. 1964</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/2/64</b>	23c. NAME OF CEMETERY OR CREMATORY <b>United Hebrew Temple</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>	
24. FUNERAL DIRECTOR <b>HERMAN RINDSKOPF INC. 5216 DELMAR</b>		25. DATE RECD. BY LOCAL REG. <b>1-1-64</b>		26. REGISTRAR'S SIGNATURE <b>John E. Murphy</b>	

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RECEIVED

NOV 19 1953

**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 John Ketter

Licensed Embalmer No. 3880

P. O. Address \_\_\_\_\_

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.

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DEPT. OF HEALTH & HUMAN SERVICES