

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **981**

Dr. Lorie  
FILED JAN 20 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>ST. Missouri</b> b. COUNTY <b>Greene</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Springfield</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>1226 E. Catalpa</b>		Length of stay in 1b <b>30 Yrs.</b>	d. STREET ADDRESS <b>1226 E. Catalpa</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>JOSEPH</b> Last <b>SASS</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>12</b> Year <b>1958</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>May 18 1901</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale Jeweler</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Sass</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Schrafter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>95-30-2084</b>	17. INFORMANT Address <b>Mrs. Sarah Sass Springfield, Mo.</b>		
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>Acute myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-5 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					" "
DUE TO (b) <u>Coronary artery Occlusion</u>					" "
DUE TO (c) <u>Arteriosclerosis 4201</u>					"
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mild Diabetes M. (no insulin required)</u>					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. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <u>3-31-53</u> , to <u>1-12-58</u> and last saw <u>him</u> alive on <u>1-10-58</u> Death occurred at <u>11:45 p. m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <u>Harold L. Lurie, M.D.</u>			22b. ADDRESS <u>609 Cherry Springfield, Mo.</u>		22c. DATE SIGNED <u>1-13-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/14/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Temple Israel</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>		
24. FUNERAL DIRECTOR <b>H.H. Lohmeyer</b>		ADDRESS <b>Springfield, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-15-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie L. Melton</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. diseases in Part 1 must be, casually related.

990 78 (ONI)  
FEB  
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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 *W. R. McCann* .....

Licensed Embalmer No. *27* .....

P. O. Address *Springfield* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.