

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015633

STATE FILE NUMBER
4045

FILED APR 18 1958

Registration District No. 318 Primary Registration District 1003

Registrar's No. 4045

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-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 0/ 1209 N. 13th		d. STREET ADDRESS (If outside, give location) 1209 N. 13th St.	

3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CANTER			4. DATE OF DEATH Month Day Year APRIL 11th, 1958		
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1896	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Maker	10b. KIND OF BUSINESS OR INDUSTRY Paint	11. BIRTHPLACE (City and state or country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jake Canter	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Unk.	16. SOCIAL SECURITY NO. 494-09-8752	17. INFORMANT Address Dr. J. J. Vizgird 3511 University St.
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18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>420.1</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from <u>Nov 1 57</u> to <u>April 5 58</u> and last saw her alive on <u>April 5 58</u> . Death occurred at <u>11:45 AM</u> m of the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. J. Vizgird M.D.</u>	22b. ADDRESS <u>3511 University St.</u>	22c. DATE SIGNED <u>4/11/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/14/58	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
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24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf Inc. 5216 Delmar	25. DATE RECD. BY LOCAL REG. APR 12 58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.
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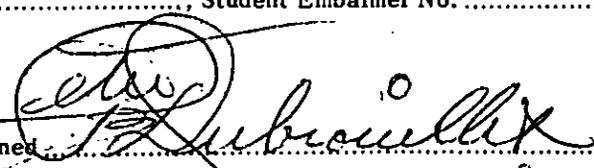
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

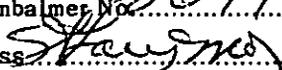
STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No. 3691

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.