Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007034
STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1084

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) ST. LOUIS, MO. Inside Limits Yes [X] No [ ]

c. CITY OR TOWN St. Louis Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. LOUIS CITY HOSP. Length of stay in 1b 35 yrs.

d. STREET ADDRESS (If outside, give location) 5097 Arsenal Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First SAM Middle Last DEWAN

4. DATE OF DEATH Month JAN. Day 30, Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH ab .1889

9. AGE (In years last birthday) ab. 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant

10b. KIND OF BUSINESS OR INDUSTRY Antigues

11. BIRTHPLACE (City and state or country) Syria

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Morris Dewan

13b. MOTHER'S MAIDEN NAME Unk.

14. NAME OF HUSBAND OR WIFE Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT Carl Dewan 3329 Castle Heights, L/A. Calif Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) generalized peritonitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) perforation of colon
DUE TO (c) ulcerative colitis 572.2
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). Status post operative ileostomy & Eleveorization of colon perforation

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 12/30/58, to 1/30/59 and last saw her/him alive on 1/30/59
Death occurred at 5:50 A.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Rhys A. Williams M.D.

22b. ADDRESS 1515 LAFAYETTE AVE

22c. DATE SIGNED 1/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.

23b. DATE 1/31/59

23c. NAME OF CEMETERY OR CREMATORY Hebrew Cem.

23d. LOCATION (City, town, or county) (State) Los Angeles, Calif.

24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson

25. DATE RECD. BY LOCAL REG. JAN 30 '59

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Lawrence J. Dunn

Licensed Embalmer No. 3988

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.