

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-033935**

**FILED OCT 13 1959**

**2 8599**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in lb	c. CITY OR TOWN <b>University City</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7414 Cornell Avenue</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY AARON JAMIESON</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 17, 1959</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>Unknown</b>
9. AGE (last birthday) <b>Abt. 56</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoes</b>	11. BIRTHPLACE (City and state or country) <b>Russia</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Sam Jamieson</b>	13b. MOTHER'S MAIDEN NAME <b>Eva Vinetz</b>
14. NAME OF HUSBAND OR WIFE <b>Sylvia L. Jamieson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk.</b>	16. SOCIAL SECURITY NO. <b>Unk.</b>
17. INFORMANT <b>Mrs. H.A. Jamieson-7414 Cornell Ave.</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) <b>Tumor of the Brain - malignant (? Glioblastoma)</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)	DUE TO (c) <b>1930</b>
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 a.m. p.m. Month, Day, Year			
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>9/10/59</b> to <b>9/17/59</b> and last saw him alive on <b>9/17/59</b> Death occurred at <b>8:10 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>9/18/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/18/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth Hamedrosh Hagood</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR <b>Herman Rindskopf, Inc.</b>	ADDRESS <b>5216 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 18 '59</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>

DOCUMENT

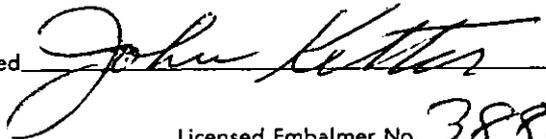
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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. 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.