URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-041673

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210694

ENDED

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri.
Length of stay in 1b

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Luke's Hospital
Inside Limits: Yes ☐ No ☐

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

c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location): 4157 Westminister Place.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Jacob Middle: M. Last: Chuchian

4. DATE OF DEATH: Month: November Day: 19 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 12/15/1880

9. AGE (last birthday): 78
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY: Shoes

11. BIRTHPLACE (City and state or country): Armenia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Unavailable

13b. MOTHER'S MAIDEN NAME: Unavailable

14. NAME OF HUSBAND OR WIFE: Sarah Chuchian

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

16. SOCIAL SECURITY NO.: 490-38-0243

17. INFORMANT: Sarah Chuchian, Address: 4157 Westminister Place.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident
INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c): Cerebral arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ 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 Nov 4, 1959, to Nov 19th, 1959 and last saw her/him alive on Nov 19, 1959
Death occurred at St. Luke's Hospital 5:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John W. Davidson [signature]

22b. ADDRESS: 600 No. Union, St. Louis 8 Mo

22c. DATE SIGNED: 11-19-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11/21/59

23c. NAME OF CEMETERY OR CREMATORY: St. Matthews Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Missouri.

24. FUNERAL DIRECTOR ADDRESS: Albert H. Hoppe, Inc., 4700 Washington

25. DATE RECD. BY LOCAL REG.: NOV 19 1959

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D. MJB.

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3 5 7

P. O. Address

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