

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 2 6 1

FILED VS JAN - 8 1960 317

Registration District No. 546 Primary Registration District No. 3211 Registrar's No.

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY St. Louis		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		c. CITY OR TOWN St. Louis		d. STREET ADDRESS (If outside, give location) 1044 Hamilton Ave.	
a. COUNTY St. Louis		b. COUNTY		e. STATE Missouri		f. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Overland		Length of stay in 1b mos.		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION Good Shepherd Nursing 9444 Midland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1044 Hamilton Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX	
First Josephine Middle F. Last Florine			Month 12 Day 2 Year 59			Female	
5. SEX Female		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-30-1900	
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min. 59		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (City and state or country) Ind.		12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Herman Schoenfield		13b. MOTHER'S MAIDEN NAME D. Thompson	
14. NAME OF HUSBAND OR WIFE Robert M Florine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address John F. Cashow Cecial Field, Florida	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Myocardial Infarction						1 hr.	
DUE TO (b) General Metastases Carcinoma of Breast						2 yrs.	
DUE TO (c) 170x							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes, Arteriosclerosis						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 8:55 A.M. Month, Day, Year 1957 Dec 2 59		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 1957 , to Dec 2 59 and last saw her/him alive on Dec 2 59 . Death occurred at 8:55 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not sign in title) Paul K. Webb M.D.				22b. ADDRESS 721 Olive St. St. Louis Mo		22c. DATE SIGNED Dec 2 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-4-1959		23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery St. Louis Co., Missouri		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark F.H. 1125 Hodiamont				25. DATE RECD. BY LOCAL REG. 12-3-59		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

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 _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Alfred J. Bresler
Licensed Embalmer No. 2663

P. O. Address 1125 Hudson

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.