

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012293

FILED VS MAR 25 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2973**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
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 ST. LUKES HOSPITAL		d. STREET ADDRESS (If outside, give location) 923rd LA SALLE	

3. NAME OF DECEASED (Type or print) First MURAD Middle ABLAN Last			4. DATE OF DEATH Month MARCH Day 12 Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC. 20, 1895	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY CITY OF ST. LOUIS		11. BIRTHPLACE (City and state or country) LEBANON SYRIA	
12. CITIZEN OF WHAT COUNTRY U - S - A.		13a. FATHER'S NAME RASH ABLAN		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE ANNIE ABLAN (DEC'D)		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.	
17. INFORMANT JOSEPH ABLAN 808 GEYER AVE		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) Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH 24 hrs
DUE TO (b) Acute Myocardial Infarction		
DUE TO (c) H2O.I		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus,		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	
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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 **11/5/59** to **3/12/60** and last saw her/him alive on **3/12/60**
Death occurred at **4 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John Davidson M.D.		22b. ADDRESS 600 Union Blvd.		22c. DATE SIGNED 3/14	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAR 15 1960	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
24. GENERAL DIRECTOR ADDRESS Thomas Katis 2906 Gravoie		25. DATE RECD. BY LOCAL REG. MAR 14 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mpe

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 James E. White

Licensed Embalmer No. 4347

P. O. Address 2906

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