

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012427

FILED VS APR 12 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 3447** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b DOA	c. CITY OR TOWN Clayton		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Barnes Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 49 Brighton Way		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle _____ Last CAPLAN			4. DATE OF DEATH Month March Day 26 Year 1960			
5. SEX Male	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 Aug. 8, 1888	9. AGE (last birthday) 71 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) Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Used Car Dealer	11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Aaron Caplan		13b. MOTHER'S MAIDEN NAME Hanna Yalem		14. NAME OF HUSBAND OR WIFE Ann		
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. Unk.	17. INFORMANT Address Ann Caplan 49 Brighton Way			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary artery occlusion DUE TO (b) arteriosclerosis DUE TO (c) 4201 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH few mins.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None					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 1932 to 1960 and last saw her/him alive on 3-26-60 Death occurred at 12:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Michael Smith M.D.			22b. ADDRESS 3720 Washington St. L. Mo.		22c. DATE SIGNED 3/24/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 3/28/60	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha		23d. LOCATION (City, town, or county) (State) University City, Mo.		
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson Avenue.			25. DATE RECD. BY LOCAL REG. MAR 27 1960	26. REGISTRAR'S SIGNATURE Coan Smith, M.D. m 85		

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 *James A. Gudberg*

Licensed Embalmer No. 4229

P. O. Address _____

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.