

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

2 2898 60-012798  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

|   |   |  |  |   |  |  |   |
|---|---|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |  |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |   | Length of stay in 1b<br><b>2 mths</b>  |  | c. CITY OR TOWN <b>University City</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>  |   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><b>6286 Gates</b>           |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First <b>JOSEPH</b> Middle <b>KAPPICO</b> Last   |   |  |  | 4. DATE OF DEATH <b>Mar. 11, 1960</b><br>Month Day Year   |  |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>unk.</b>   | 9. AGE (last birthday)<br><b>ab. 91</b>                                      | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dealer</b>  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Scrap Metal</b>                              |   | 11. BIRTHPLACE (City and state or country)<br><b>USSR</b>                    |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USSR</b>  |
| 13a. FATHER'S NAME<br><b>Morris Kappico</b>   |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Unk.</b>   |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Rebecca</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT Address<br><b>Rebecca Kappico 6286 Gates</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>  |   |  |  |   |  |  |   |
| Conditions, if any, which gave rise to above cause (s), stating the underlying cause last. DUE TO (b) <b>Acute Myocardial Infarction</b> <b>3-4 hrs</b>   |   |  |  |   |  |  |   |
| DUE TO (c) <b>Coronary Artery Disease</b> <b>6 yrs</b>  |   |  |  |   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>420.1</b>   |   |  |  |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour a.m. p.m.<br>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>Oct. 1956</b> to <b>March 11, 1960</b> and last saw <sup>him</sup> <del>her</del> alive on <b>Mar. 11, 1960</b><br>Death occurred at <b>9:55 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><b>Murray Chinsky M.D.</b>  |   |  |  | 22b. ADDRESS<br><b>6223 Natural Budge</b>   |  | 22c. DATE SIGNED<br><b>3/12/60</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem.</b>  |   | 23b. DATE<br><b>3/13/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chesed Shel Emeth</b>                       |   | 23d. LOCATION (City, town, or county) (State)<br><b>University City, Mo.</b> |  |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Berger Memorial 4715 McPherson</b>   |   |  |  | 25. DATE RECD. BY LOCAL REG.<br><b>MAR 12 1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Loan Smith, M.D.</b>   |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(H.T.)

**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 *David A. Gendry*

Licensed Embalmer No. 4339

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.