

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

60-013309

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1421 Claytonia Terrace</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Esa</b> Last <b>Totah</b>			4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1883</b>	9. AGE (last birthday) <b>86 76</b>	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) <b>Candy Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>		11. BIRTHPLACE (City and state or country) <b>Ramallah, Palestine</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Esa Totah</b>		13b. MOTHER'S MAIDEN NAME <b>Zagloulah Shatara</b>		14. NAME OF HUSBAND OR WIFE <b>Katie M. Totah</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>110-16-8927</b>	17. INFORMANT <b>Mrs. John Totah</b>	Address <b>1421 Claytonia Terrace</b>
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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 <b>(day)</b>
IMMEDIATE CAUSE (a) <b>acute myocardial failure</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>arteriosclerotic heart disease</b>	
DUE TO (c) <b>420.0</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 **3-10-1960** to **3-13-1960** and last saw her alive on **3-13-60**  
Death occurred at **11:30 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Arthur K. Truskef M.D.</b>	(Degree or title)	22b. ADDRESS <b>7500 Paradise</b>	22c. DATE SIGNED <b>3-14-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 16, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Missouri</b>
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24. FUNERAL DIRECTOR <b>C.R. Lupton and Sons 7233 Delmar Blv'd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 15 1960</b>	26. REGISTRAR'S SIGNATURE <b>Harold Smith M.D.</b>
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BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

DOCUMENT

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 Arnold W. Schoen

Licensed Embalmer No. 3864  
P. O. Address St. Louis

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.