

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 31 1960

1377 =60-021955

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1376

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo.</u>		Length of stay in 1b <u>12 days</u>	c. CITY OR TOWN <u>University City</u> <del>St. Louis</del>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7335 Cornell</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sam</u> Middle <u>Leo (none)</u> Last <u>Weitzbuch</u>			4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>60</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-73</u>	9. AGE (last birthday) <u>88 yrs</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Sorter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-Scrap metal-</u>	11. BIRTHPLACE (City and state or country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Jacob Weitzbuch</u>	13b. MOTHER'S MAIDEN NAME <u>Unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Pearl Weitzbuch</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Records Koch Hospital, Koch, Mo</u>
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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: IMMEDIATE CAUSE (a) <u>Diabetic Gangrene left foot</u>		INTERVAL BETWEEN ONSET AND DEATH <u>(?)</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes mellitus</u>		<u>(?)</u>
DUE TO (c) <u>  </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>		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.)
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20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>  </u>
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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
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21. I attended the deceased from <u>4-15-60</u> to <u>4-26-60</u> and last saw him alive on <u>4-25-60</u>
Death occurred at <u>7:40</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H.A. Harris</u> (Name or title) <u>MD</u>	22b. ADDRESS <u>Koch Hospital, Koch, Mo</u>	22c. DATE SIGNED <u>4-26-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u>	25. DATE RECD. BY LOCAL REG. <u>4-26-60</u>	26. REGISTRAR'S SIGNATURE <u>J. M. Muffly</u>
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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

*Lawrence J. Davis*

Licensed Embalmer No. 3988

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.