

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036467

FILED VS. SEP 28 1960

318

Registration District No. Primary Registration District No. 1003

Registrar's No. 9148

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>			Length of stay in 1b		c. CITY OR TOWN <b>Clayton</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>500 S. Merramec</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ISADORE (ISSIE) NMN POULIN</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 15 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>8/25/90</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manufacturer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Curtain</b>	11. BIRTHPLACE (City and state or country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>DAVID POULIN</b>		13b. MOTHER'S MAIDEN NAME <b>UNK.</b>		14. NAME OF HUSBAND OR WIFE <b>MAY POULIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>UNK.</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>	17. INFORMANT Address <b>Mrs. May Poulin 500 S. Merramec</b>		
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) <b>SHOCK</b>					<b>4 HOURS</b>
DUE TO (b) <b>MYOCARDIAL INFARCTION, SUSPECTED</b>					<b>4 HOURS</b>
DUE TO (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b> <b>4201</b>					<b>69 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>BRONCHOPNEUMONIA, LEFT LOBE</b>					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 Month, Day, Year a.m. p.m.					
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>AUG. 4, 1960</b> to <b>SEPT. 15, 1960</b> and last saw her/him alive on <b>SEPT. 15, 1960</b> Death occurred at <b>2:35 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>F. R. Bradley</i> <b>F. R. BRADLEY, M.D.</b>			22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>9/15/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/18/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Herman Rindskopf Inc. 5216 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 16 1960</b>		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JANUARY 1954

**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 Peter B. Dubrow

Licensed Embalmer No. 3691

P. O. Address. St. Louis

JANUARY 1954

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.