

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

50-036766

FILED VS/ SEP 19 1960

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2735

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>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		Length of stay in 1b <u>3 mths.</u>		c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>764 Leland City</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>764 Leland</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MORITZ M.</u> Middle <u>SCHAPER</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/9/1882</u>	9. AGE (last birthday) <u>78</u>	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) <u>Employer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Y.M.H.A</u>		11. BIRTHPLACE (City and state or country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Abr. Schaper</u>			13b. MOTHER'S MAIDEN NAME <u>Fanny (unk)</u>			14. NAME OF HUSBAND OR WIFE <u>Leah</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT Address <u>Alfred Schaper 764 Leland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Coronary arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 hr.</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 <u>May 8 1959</u> to <u>Sept 14 1960</u> and last saw ^{her} him alive on <u>May 9 1960</u> Death occurred at <u>800 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Barrett L. Tausig M.D.</u>				22b. ADDRESS <u>4500 Olive St.</u>			22c. DATE SIGNED <u>9/15/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.</u>		23b. DATE <u>9/16/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>		23d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u>				25. DATE RECD. BY LOCAL REG. <u>9-15-60</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>		

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

Quinn J. Judurg

Licensed Embalmer No. 4229

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.