

## OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019715

STATE FILE NUMBER

AMENDED

Registration District No. <u>317</u>		Primary Registration District No. <u>590</u>		Registrar's No. <u>1492</u>		STATE FILE NUMBER	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u> Length of stay in lb <u>3 yrs. 2 mos.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST Louis</u> c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9520 Latus, CLAYTON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Marjorie</u> Middle <u>Feldman</u> Last <u>Corn</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>28</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-15-92</u>	
<b>9. AGE</b> (last birthday) <u>69</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>New York City, N.Y.</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Mannus Feldman</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Sarah Markel</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Morris Corn (Deceased)</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>17. INFORMANT</b> <u>Mr. Joseph Corn Son,</u> <u>9520 Clayton Rd., St. Louis 17, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u> <u>Generalized Osteoarthritis</u> DUE TO (c) <u>Chronic Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>II</u> <u>II</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Chronic Brain Syndrome due to Cer. Arteriosclerosis</u>					PART III. If deceased <input checked="" type="checkbox"/> as female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> / <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> _____ <b>STATE</b> _____	
<b>21. I attended the deceased from</b> <u>March 1, 1958</u> to <u>May 28, 1961</u> and last saw her <sup>her</sup> alive on <u>May 27, 1961</u> Death occurred at <u>4:10 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)				<b>22b. ADDRESS</b> <u>7301 St. Charles Rock Rd.</u>		<b>22c. DATE SIGNED</b> <u>5/28/61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>5/29/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Sinai</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>8400 Gravois Ave</u>	
<b>24. FUNERAL DIRECTOR</b> <u>MAYER</u> <u>4356 LINDELL BLVD</u> ADDRESS				<b>25. DATE RECD. BY LOCAL REG.</b> <u>5-29-61</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>John C. Murphy Md.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 Harry E. Monro

Licensed Embalmer No. 4495

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.