

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-012625

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3416**

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 12 1962

VS 300  
Rev. 4/59

1

2 **210**

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12 **92-3**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
		<b>St. Louis</b>		<b>66 yrs</b>		<b>Mo.</b>				<b>St. Louis</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
<b>DOA City Hosp,</b>						<b>3046 Fair</b>									
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		5. SEX							
First		Middle		Last		<b>Mar. 29, 1962</b>		<b>Male</b>		<b>White</b>		<b>Never Married</b> <input checked="" type="checkbox"/>		6. COLOR OR RACE	
<b>ABRAHAM</b>		<b>FELDMAN</b>													
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
						<b>10/12/1895</b>		<b>66</b>		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
<b>Employee</b>				<b>Lighthouse for Blind</b>				<b>St. Louis, Mo.</b>							
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
<b>Jos. Feldman</b>				<b>Anna Yatkeman</b>				<b>Esther</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
<b>No</b>				<b>Unk.</b>				<b>Minnie Becker</b>				<b>1020 Chartres</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>Chronic Myocarditis</b>															
DUE TO (b)															
<b>Atherosclerosis</b>															
DUE TO (c)															
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											
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 _____ to _____ and last saw her/him alive on _____.															
Death occurred at _____ <b>10:20 P.</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Of the reporter)						22b. ADDRESS				22c. DATE SIGNED					
<b>Paul Simon</b>						<b>1308 Clark</b>				<b>3/30/62</b>					
23a. BURIAL, CREATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)							
<b>Rem.</b>		<b>4/2/62</b>		<b>Chesed Shel Meth</b>				<b>University City, Mo.</b>							
24. FUNERAL DIRECTOR				25. DATE RECD. BY LOCAL REG.				REGISTRAR'S SIGNATURE							
<b>Berger Memorial 4715</b>				<b>MAR 30 1962</b>				<b>Lois Smith, M.D.</b>							
ADDRESS				ADDRESS				ADDRESS							
<b>c herson</b>															

USE BLACK INK OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Quis J. Guderg*  
Licensed Embalmer No. 4229

P. O. Address \_\_\_\_\_

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.