

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-017250

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4146**

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 1 1962

VS 300
Rev. 4/59

1
2 **216**
3
4 **0**
5 **1**
6
7 **2**
8 **2**
9
10
11
12 **3-0**
13

DATE AMENDED
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
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															
		ST. LOUIS				MO.																	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits		d. STREET ADDRESS		(If outside, give location)		Reside on Farm															
INCARNATE WORD HOSP		Yes <input type="checkbox"/> No <input type="checkbox"/>		2836 MINNESOTA				Yes <input type="checkbox"/> No <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			Month			Day			Year		
			JOHN			SEIFERT						APRIL			19			1962					
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											
MALE		WHITE				SEPT. 13 / 1876		85		Months		Days		Hours		Min.							
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											
RETIRED SHOE WORKER								AUSTRIA HUNGARY U-S-A															
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE															
JOHN SEIFERT				UNKNOWN				ANNA SEIFERT															
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											
NO								ANNA SEIFERT 2836 MINNESOTA															
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH													
IMMEDIATE CAUSE (a)										Coronary occlusion E Myocardial infarct 4/9													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										4201													
DUE TO (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.													
										Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>													
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.																					
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													
						4/9		4/19															
21. I attended the deceased from Death occurred at										and last saw her/him alive on													
845A										4/19													
22a. SIGNATURE										22b. ADDRESS										22c. DATE SIGNED			
Ralph Berg MD										32038 Grand										4/19/62			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)																	
BURIAL		APR. 23. 1962		ST PETER + PAUL CEM.		ST. LOUIS																	
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.				26. REGISTRAR'S SIGNATURE											
Thomas Kutis 2906 Gravois								APR 23 1962				NOAN SMITH. M.D.											

USE BLACK INK OR TYPEWRITER RIBBON

63

Dr. Reginald Berg RA3-7857

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

Eleanor Province

Licensed Embalmer No.

3403

P. O. Address

2906 grovois

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.