

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021119

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4861**

FILED MAY 23 1962

VS 300 Rev. 4/59	RATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF
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1. PLACE OF DEATH a. COUNTY St. Louis Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 5320 Pershing	
3. NAME OF DECEASED (Type or print) First Josephine Middle B. Last Wallstein		4. DATE OF DEATH Month 5 Day 12 Year 62	
5. SEX female	6. COLOR OR RACE w.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/20/84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis Mo.
13a. FATHER'S NAME Julius Wallstein		13b. MOTHER'S MAIDEN NAME Pauline Weill	14. NAME OF HUSBAND OR WIFE XXXXXXXXXXXX
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT (Name and address) Arrangement) 5/10/60. 5370 Pershing Josephine Wallstein (Time of Funeral)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 weeks 5 years
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 St. Louis COUNTY STATE
21. I attended the deceased from May, 1961 to May 12, 1962 and last saw her alive on May 12, 1962 . Death occurred at 6:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John T. Linton, M.D.		22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED May 13, 1962
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 5/14/62	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai	23d. LOCATION (City, town, or county) 8400 Gravois Ave
24. FUNERAL DIRECTOR MAYER		25. DATE RECD. BY LOCAL REG. MAY 14 1962	26. REGISTRAR'S SIGNATURE Coard Smith, M.D.

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

Etienne P. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.