

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025168

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6204**

DO NOT WRITE ON THIS STUB

AMENDED

**FILED JUL 2 1962**

VS 300  
Rev. 4/59

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*50*

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Length of stay in lb <b>1 Day</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY		c. CITY OR TOWN <b>St. Louis (11)</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Brothers Hosp</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7317 Michigan Ave</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward Schwartz</b>			First Middle Last			4. DATE OF DEATH <b>6-20-1962</b>			Month Day Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-1906</b>		9. AGE (last birthday) <b>55 Years</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Produce</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Theodore Schwartz</b>				13b. MOTHER'S MAIDEN NAME <b>Ann Wisniski</b>				14. NAME OF HUSBAND OR WIFE <b>Nellie Schwartz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Nellie Schwartz 7317 Michigan Ave (11)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>4201</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>unk</b>	
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 checked="" type="checkbox"/> NO <input 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 a.m. p.m. 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 <b>6/20/62</b> to <b>6/20/62</b> and last saw him alive on <b>6/20/62</b> Death occurred at <b>8:25 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Henry Cooper M.D.</i>						22b. ADDRESS <b>818 Olive St.</b>			22c. DATE SIGNED <b>6/22/62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6-23-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>			23d. LOCATION (City, town, or county) <b>10160 Gravois Rd.</b>				
24. FUNERAL DIRECTOR <b>Fendler Und. Co 7420 Michigan (11)</b>						25. DATE RECD. BY LOCAL REG. <b>JUN 22 1962</b>		25. REGISTRAR'S SIGNATURE <i>Edna Smith M.D.</i>			

Dr. Benjamin  
No. 2-2340

**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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Michigan

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.