

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-028603  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7676**

**FILED AUG 13 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1	
2	2/29
3	2
4	1
5	2
6	
7	1
8	1
9	
10	
11	
12	86-0
13	86

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>Unknown</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</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>Masonic Home Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5351 Delmar Blvd.</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <b>Margarette</b> Middle <b>Weiss</b> Last <b>Ehrenreich</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>4</b> Year <b>1962</b>			5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>1/3/84</b>		9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Western Union</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Telegraph</b>				11. BIRTHPLACE (City and state or country) <b>New York, N.Y.</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>											
13a. FATHER'S NAME <b>Julius Weiss</b>				13b. MOTHER'S MAIDEN NAME <b>Hedwig Weinberg</b>				14. NAME OF HUSBAND OR WIFE <b>Herman S. Ehrenreich</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.				17. INFORMANT Address <b>Masonic Home of Mo. <i>Louisiana</i> Subit</b>			
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>												<b>24 Hours</b>											
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.												DUE TO (b) <b>Generalizes arteriosclerosis</b>				<b>Unknown</b>							
DUE TO (c) <b>Diabetes Mellitus</b> <b>260X</b>												<b>Unknown</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 checked="" 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.) <b>None</b>		20c. TIME OF INJURY Hour <b>None</b> a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. CITY, TOWN, OR LOCATION <b>None</b>		COUNTY		STATE							
21. I attended the deceased from <b>April 21, 1960</b> to <b>Aug. 4, 1962</b> and last saw her/him alive on <b>Aug. 4, 1962</b> Death occurred at <b>10:15 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.												22a. SIGNATURE (Degree or title) <b>Harold E. Walters, M.D.</b>				22b. ADDRESS <b>3720 Washington St. Louis</b>				22c. DATE SIGNED <b>8-5-62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/7/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>W.S. Union</b>				23d. LOCATION (City, town, or county) <b>St. Louis</b>				23e. STATE											
24. FUNERAL DIRECTOR <b>Mayer</b>				ADDRESS <b>4356 Lindell</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 6 1962</b>				26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</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

~~\_\_\_\_\_~~ *J. W. Wensley*

Licensed Embalmer No. 2653

P. O. Address J. A. Rink

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.

*W*