

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032878

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8434 STATE FILE NUMBER

FILED SEP 10 1962

VS 300 Rev. 4/59

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DATE AMENDED 9-27-62

INSTEAD OF 10-7-61

ITEM NO. SHOULD READ 10-5-83

BY AFFIDAVIT OF *Funeral Director* DOCUMENT *Using Registration Record*

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>University City</u> Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6609 Enright</u> Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GUSSTIE</u> Middle <u>SCHNEIDER</u> Last <u>105-83</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/1891</u>
9. AGE (last birthday) <u>80</u> <u>78</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>8</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work history. If retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Zmeil Schuckman</u>	
13b. MOTHER'S MAIDEN NAME <u>Tillie (unk)</u>		14. NAME OF HUSBAND OR WIFE <u>Max</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>No</u> unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Max Schneider</u> Address <u>6609 Enright</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>5 years</u>
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.) <u>260x</u>	
20c. TIME OF INJURY Hour <u>5:15</u> p.m. Month, Day, Year <u>8/29/62</u>		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 <u>University City, Mo.</u>	
21. I attended the deceased from <u>2/16/62</u> to <u>8/29/62</u> and last saw her alive on <u>8/29/62</u> Death occurred at <u>5:15 pm</u> <u>8/29/62</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <u>Jail Rosten Zeffen MD</u>	
22a. SIGNATURE (Degree or title)		22b. ADDRESS <u>2428 Woodland Rd</u>	22c. DATE SIGNED <u>8/30/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem.</u>	23b. DATE <u>8/30/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chebra Kadisha</u>	23d. LOCATION (City, town, or county) <u>University City, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 Mcpherson</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 30 1962</u>	26. REGISTRAR'S SIGNATURE <u>Coal Smith. M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

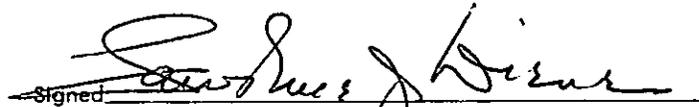
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 3988

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.