

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-036312
8660 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED SEP 17 1962

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| VS 300 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DATE AMENDED |
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| USE BLACK INK OR TYPEWRITER RIBBON | SHOULD READ |
| BY AFFIDAVIT OF | DOCUMENT |

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|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | |
| Length of stay in lb | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5436A GILMORE AVE.</u> | | d. STREET ADDRESS (if outside, give location) <u>5436A GILMORE AVE.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>J.</u> Last <u>JAMSHEK</u> | | 4. DATE OF DEATH Month <u>SEPT.</u> Day <u>4,</u> Year <u>1962</u> | |
| 5. SEX <u>MALE</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>4-25-06</u> |
| 9. AGE (last birthday) <u>56</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PAS. BUS</u> | 11. BIRTHPLACE (City and state or country) <u>COLLINSVILLE, ILL.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> | | 13a. FATHER'S NAME <u>JOSEPH JAMSHEK</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>VIVIAN JAMSHEK</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR II</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>VIVIAN JAMSHEK</u> | | Address <u>5436A GILMORE</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>Acute myocardial infarction.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <i>OK by J. M. Smith, Deputy Coroner 9-7-62</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> | | 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 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 _____ 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 _____ to _____ and last saw her/him alive on <u>8-23-62</u> Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>J. M. Smith M.D.</u> | | 22b. ADDRESS <u>U. Club Bldg</u> | 22c. DATE SIGNED <u>9/5/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>SEPT 7, 62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u> | 23d. LOCATION (City, town, county) (State) <u>ST. LOUIS COUNTY MO.</u> |
| 24. FUNERAL DIRECTOR <u>STROTT CARROLL 4600 NAT. BRIDGE</u> | | 25. DATE RECD. BY LOCAL REG. <u>SEP 7 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Joan Smith M.D.</u> |

9580

Dr. Carmon
Dr. [unclear]
2 237
2 to 3:30 pm

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 M W Rueter

Licensed Embalmer No. 4865

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.