

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-040467
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10489**

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 13 1962

1. PLACE OF DEATH a. COUNTY		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) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL		d. STREET ADDRESS (If outside, give location) 3524th TEXAS AVE	

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE LOVITZ			4. DATE OF DEATH Month Day Year OCT 30 1962			
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH OCT 28 1913	9. AGE (last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GLOVE MAKER CARLINVILLE GLOVE CO	10b. KIND OF BUSINESS OR INDUSTRY UNK.	11. BIRTHPLACE (City and state or country) U-S-A	12. CITIZEN OF WHAT COUNTRY U-S-A
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13a. FATHER'S NAME SAMUEL A ENGLAND	13b. MOTHER'S MAIDEN NAME MINNIE D DALTON	14. NAME OF HUSBAND OR WIFE JOHN LOVITZ
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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.	17. INFORMANT Address JOHN LOVITZ 3524th TEXAS AVE
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18. CAUSE OF DEATH (Enter only one cause per line if more than one. DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) Pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 2 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of breast with metastases to spine	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170X	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
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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.)
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20c. TIME OF INJURY Hour s.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
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21. I attended the deceased from OCT 1961 to OCT 30 1962 and last saw her/him alive on OCT 30 1962	
Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <i>Blair M. Over</i> M.D.	22b. ADDRESS 114 N. Taylor Ave. St. Louis, Mo.	22c. DATE SIGNED 10/31/62
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE NOV 2, 1962	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY GREENFIELD	23d. LOCATION (City, town, or county) (State) 16th.
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24. GENERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. NOV 1 1962	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DATE AMENDED

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF SHOULD READ

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 *Barry A. King*

Licensed Embalmer No. 48601

P. O. Address *W. King 19th*

*Dr. J. L. Bryant 114 St. Taylor
Rt. 1, Cambridge, Pa. 3-8600*

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.