

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040523

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

10568

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED NOV 13 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

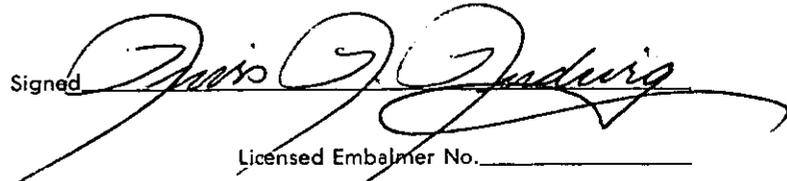
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		Length of stay in 1b <b>8 wks.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>Kirksville</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>Jewish Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1762 E. Washington</b>	
3. NAME OF DECEASED (Type or print) First <b>LEA</b> Middle <b>MERIN</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1962</b>			
5. SEX <b>Female</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>12/15/1918</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Poland</b>	
13a. FATHER'S NAME <b>Jos. Riba</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>		14. NAME OF HUSBAND OR WIFE <b>Leo</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leo Merin 1762 e. Washington, Kirksville, Mo.</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>Pulmonary Terminal</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Poleudema</b> DUE TO (c) <b>Pulmonary fibrosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>525X</b>				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.)			
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>Sept 19 - 1962</b> to <b>Nov 7 - 1962</b> and last saw her alive on <b>Nov 1 - 1962</b> Death occurred at <b>2 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Herman M. Meyer M.D.</b>			22b. ADDRESS <b>4409 West Pine Blvd</b>		22c. DATE SIGNED <b>11/3/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>		23b. DATE <b>11/5/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai</b>		23d. LOCATION (City, town, or county) (State) <b>Arton, Mo.</b>
24. FUNERAL DIRECTOR <b>Berger Memorial 4715 Cherson</b>			25. DATE RECD. BY LOCAL REG <b>Nov. 4 1962</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith. M.D.</b>

**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. \_\_\_\_\_  
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.