

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044938

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11003

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 26 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

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|-------------------------------------|--|--|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis | | Length of stay in 1b 2 weeks | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | c. CITY OR TOWN University City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6327 Cates Ave. | | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HARRY SUFFIAN | | | | | | 4. DATE OF DEATH Month Day Year November 15, 1962 | | | | | | | |
| 5. SEX Male | | 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 1/14/1892 | | 9. AGE (last birthday) 70 | | 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) Decorator | | | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (City and state or country) Russia | | | 12. CITIZEN OF WHAT COUNTRY USA | | | | |
| 13a. FATHER'S NAME Shomel Suffian | | | | 13b. MOTHER'S MAIDEN NAME Yetta Suffian | | | | 14. NAME OF HUSBAND OR WIFE Yetta | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Yetta Suffian 6327 Cates Avenue | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> DUE TO (b) <i>Diabetes mellitus</i> Underlying cause (c) <i>260x</i> <i>1-15-62</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>9 days chronic</i> | | | |
| 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 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 <i>8/12/49</i> to <i>11/15/62</i> and last saw him alive on <i>11/14/62</i> Death occurred at <i>8:25 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22. SIGNATURE <i>Richardas MD</i> | | | | | | 22b. ADDRESS <i>609 No Grand</i> | | | 22c. DATE SIGNED <i>12/15/62</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 11/16/1962 | | 23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha | | | | 23d. LOCATION (City, town, or county) University City, Missouri | | | | | |
| 24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson Avenue | | | | | | 25. DATE RECD. BY LOCAL REG. NOV 15 1962 | | 26. REGISTRAR'S SIGNATURE <i>Mad Smith. M.D.</i> | | | | | |

DR CHARNAS - 607N. GRAND

USE BLACK INK OR TYPEWRITER RIBBON

NOV 28 1962

MISSOURI STATE BOARD OF HEALTH

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 *Quis J. Jendurg*
Licensed Embalmer No. 4229

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.