

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003764

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **651** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 25 1963

VS 300
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

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | | | | | | | | | |
|---|--|---|-------|---|--|---|---------------------------------------|--|------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | | | | | | | |
| St. Louis Mo. | | St. Louis | | | | Mo. | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) | | | | | | | | | |
| 5370 Pershing Ave | | | | | | 5370 Pershing Ave | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | | Middle | | | Last | | | | | | |
| FLOESSIE | | | | | | LEESER | | | 4. DATE OF DEATH | | | | | | |
| | | | | | | | | | 1 20 1963 | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HR Hours Min. | | | |
| Female | | White | | | | 5/2/90 | | 72 | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and state or country) | | | | 12. CITIZEN OF WHAT COUNTRY | | | |
| Bookkeeper | | | | | | | | Denver Colo. | | | | | | | |
| 13a. FATHER'S NAME | | | | 13b. MOTHER'S MAIDEN NAME | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | |
| Abraham Marks | | | | Dora Cohn | | | | Arthur Leaser (Dec'd) | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Address | | | | | | | |
| no | | | | | | | | Mrs. Evelyn Cohn 7453 Park Town, South | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| and DUE TO (b) chronic pyelonephritis with uremia | | | | | | | | | | years | | | | | |
| DUE TO (c) arteriosclerotic heart disease | | | | | | | | | | years | | | | | |
| 6000 | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | | | | | | | | | 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 3/10/61 to 1/20/63 and last saw her alive on 1/19/63 Death occurred at 10 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Death or title) | | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | | | | | |
| Max S. Mauldin MD | | | | | | 607 N. Grand | | | 1/21/63 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town, or county) | | | 1 (State) | | | | | |
| removal | | 1/22/63 | | Mt. Sinai | | | 8400 Gravois Ave | | | | | | | | |
| 24. FUNERAL DIRECTOR Address | | | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | | | | | | | | | |
| 4356 Lindell Blvd | | | | JAN 21 1963 | | Paul Smith MD | | | | | | | | | |

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 Harvey Kilde

Licensed Embalmer No. 4596

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.