

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004224

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1026 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH: a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 221 A SO. BROADWAY		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle ULMAN Last ULMAN						4. DATE OF DEATH Month JAN. Day 17, Year 1963					
5. SEX MALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 2/1/81		9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) NO				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) MINN.		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME PETE				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO						17. INFORMANT Address ST. LOUIS CITY HOSP. #1.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia of Othmenia cell										INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Articulation, cerebral vascular disease											
DUE TO (c) 332x											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bilateral bronchopneumonia										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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 1/11/63 to 1/17/63 and last saw her alive on 1/17/63 Death occurred at 12:20 p m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) Law B. Myers, M.D.						22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 1/17/63			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 1-20-63		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.					
24. FUNERAL DIRECTOR'S NAME AND ADDRESS ROBERT KOWALSKI 4104 Manchester Ave. St. Louis 10, Mo.						25. DATE RECD. BY LOCAL REG. JAN 31 1963		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.			

DATE AMENDED
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

75

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.