

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009687

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered District No. 316 Primary Registration District No. 1003 Registrar's No. 1456

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1032 a Veronica Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>E.</u> Last <u>Zeip</u>			4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>63</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Credit Office</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
13a. FATHER'S NAME <u>Fred Lenz</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Menke</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>		17. INFORMANT <u>Margaret Lenz, 1032 a Veronica</u> Address	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
DUE TO (c) <u>332x</u>		<u>10 years</u>	
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 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 <u>5.19.53</u> to <u>2.8.63</u> and last saw her <u>alive</u> on <u>2.8.63</u> Death occurred at <u>3:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Chas Jost M.D.</u> (Degree or title)		22b. ADDRESS <u>6000 W. Flourmont</u>	22c. DATE SIGNED <u>2-9-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>2/11/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem Luth. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Black Jack Mo.</u>
24. FUNERAL DIRECTOR <u>Drehmann-Harral</u> ADDRESS <u>1905 Union</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 11 1963</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Charles A. Jost
6000 W. Florissant

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 Albert R. Thompson

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.