

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009693  
1936 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

**FILED MAR 8 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN: <b>Sullivan</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location): <b>Rt. # 2</b>	
3. NAME OF DECEASED (Type or print) First: <b>JOSEPH</b> Middle: <b>W.</b> Last: <b>ZRAICK</b>		4. DATE OF DEATH Month: <b>FEBRUARY</b> Day: <b>18</b> Year: <b>1963</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH: <b>2/15/1872</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Retired Glass Worker</b>		11. BIRTHPLACE (City and state or country): <b>France</b>	12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>
13a. FATHER'S NAME: <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE: <b>Minnie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates): <b>No.</b>		17. INFORMANT Address: <b>Angile Goin, St. Clair, Missouri.</b>	
18. CAUSE OF DEATH (Enter only one cause for terminal disease) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PROBABLE PULMONARY INFARCT</b> DUE TO (b) <b>SUBCAPITAL FRACTURE RIGHT HIP</b> DUE TO (c) <b>904.0-21</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <b>2-25-63</b> 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			INTERVAL BETWEEN ONSET AND DEATH <b>16 Hrs.</b> <b>2 weeks</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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: <b>2</b> Month: <b>4</b> Day: <b>63</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): <b>In home</b>		20f. CITY, TOWN, OR LOCATION: <b>Sullivan</b> COUNTY: <b>Mo.</b> STATE: <b>Mo.</b>	
21. I attended the deceased from <b>12/3/48</b> to <b>2/18/63</b> and last saw her/him alive on <b>2/18/63</b> Death occurred at <b>1:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS: <b>BARNES HOSPITAL</b>	
22a. SIGNATURE: <i>C.D. Vemiller</i> (Degree or title): <b>M.D.</b>		22c. DATE SIGNED: <b>2/19/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify): <b>Removal</b>	23b. DATE: <b>2-21-63</b>	23c. NAME OF CEMETERY OR CREMATORY: <b>I.O.O.F. Cemetery</b>	
23d. LOCATION (City, town, or county): <b>St. Clair, Missouri.</b> (State)		25. DATE RECD. BY LOCAL REG.: <b>FEB 21 1963</b>	
24. FUNERAL DIRECTOR: <b>Casey -Lenox Funeral Home, St. Clair, Mo.</b> ADDRESS		26. REGISTRAR'S SIGNATURE: <i>Lead Smith, M.D.</i>	

**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 Kahle*

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.