

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-014207

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 695

STATE FILE NUMBER

FILED MAR 18 1963

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>University City</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>6238 Cabanne</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6238 Cabanne</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>Horowitz</u> Last <u>Horowitz</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint</u>	9. AGE (last birthday) <u>82</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Samuel Horowitz</u>		13b. MOTHER'S MAIDEN NAME <u>Leah Goldenberg</u>	14. NAME OF HUSBAND OR WIFE <u>Sophie Horowitz</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no; or unknown) (If yes, give war or dates of) <u>Unk</u>		17. INFORMANT Address <u>Louis Horowitz 8204 Balson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from esophageal varices</u> DUE TO (b) <u>Cerebrosis</u> DUE TO (c) <u>Atherosclerotic heart disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>Chronic</u> <u>Chronic</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 type="checkbox"/> No <input type="checkbox"/> Unknown
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 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>June 1959</u> to <u>Feb 27, '63</u> and last saw him alive on <u>8/21/61</u> Death occurred at <u>10:50 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>D. Charles MD</u>		22b. ADDRESS <u>607 No Grand</u>	22c. DATE SIGNED <u>2/28/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-1-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth Cem. St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>Herman Rindskopf Inc. 5212 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>2-28-63</u>	26. REGISTRAR'S SIGNATURE <u>John M. Murphy MD</u>

USE BLACK INK
OR
TYPEWRITER RIBBON

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

John B. Dubrouillet

Licensed Embalmer No.

3691

P. O. Address

Shawnee

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.