

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-018679

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1170

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 16 1963

1. PLACE OF DEATH a. COUNTY Koch, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits; give TOWNSHIP, only) OR TOWN St. Louis		Length of stay in 1b 348 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS Park Forest Hotel (If outside, give location) 4910 W. Pine Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Joseph Vincent			4. DATE OF DEATH March 15, 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 10-5-88	9. AGE (last birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Rudolph Vincent		13b. MOTHER'S MAIDEN NAME Matti ?		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 serv)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Robt. Koch Hosp. record, Koch, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 25 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 4200			

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	
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		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 4-2-62 to 3-15-63 and last saw her/him alive on 3-15-63
 Death occurred at 10:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Bernard Friedman, MD		22b. ADDRESS Robt. Koch Hosp. Koch, Mo.		22c. DATE SIGNED 3-16-63	
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23a. BURIAL, CREMATION, or other disposition North Aker Mortuary Service		23b. DATE 4-2-63		23c. NAME OF CEMETERY OR CREMATORY Anatomical		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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24. FUNERAL DIRECTOR'S NAME AND ADDRESS St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. 4-2-63		26. REGISTRAR'S SIGNATURE <i>John M. Murphy</i>	
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION BY AFFIDAVIT OF

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 _____

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.