

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 8 1949

State File No. 10087
2879
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10087 2879	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY <i>MAI</i>			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 59 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		OR TOWN 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp. 0				d. STREET ADDRESS (If rural, give location) 5914 1/2 Bartmer St			
3. NAME OF DECEASED (Type or Print) LENA		a. (First)		b. (Middle) GORDON		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Mar. 29, 1949		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH Ab 1907		9. AGE (In years last birthday) Ab. 41		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner		10b. KIND OF BUSINESS OR INDUSTRY Manf. Womens' cld.		11. BIRTHPLACE (State or foreign country) Russia 6		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Pinkus Gordon		13b. MOTHER'S MAIDEN NAME Hannah Unk.		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. R. Rubinowitz 1270 Hamilton			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Metastatic Carcinoma of Lung</i> DUE TO (c) <i>Primary Carcinoma of Ovary</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 49 1957	
19a. DATE OF OPERATION <i>none</i>		19b. MAJOR FINDINGS OF OPERATION <i>none</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>St. Louis Mo</i>		21f. HOW DID INJURY OCCUR? <i>None</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <i>5 March, 1949</i> , to <i>29 March, 1949</i> , that I last saw the deceased alive on <i>29 March, 1949</i> , and that death occurred at <i>10:30 a.m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree of title) <i>William J. Conrad J. M.D. U</i>		23b. ADDRESS <i>216 S. Kingshighway</i>		23c. DATE SIGNED <i>30 March 49</i>			
24a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>3/31/49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth</i>		24d. LOCATION (City, town, or county) (State) <i>University City Mo</i>	
DATE REC'D BY LOCAL REG. <i>MAR 30 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Sasater</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Berger Memorial 4715 McPherson</i>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Signed..... *Quero A. Ludwig*

Signed.....

Student Embalmer

Licensed Embalmer No. *4229*

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 this body is not embalmed, fact should be so stated above.