

FILED MAY 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18045**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076** Registrar's No. **808**

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

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Rural: Airport Township		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1426 Belt	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Sanatorium		3. NAME OF DECEASED a. (First) Aaron b. (Middle) _____ c. (Last) Becker	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	4. DATE OF DEATH (Month) (Day) (Year) April 1 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Wood work	8. DATE OF BIRTH 1879	9. AGE (In years last birthday) Months Days 70 years 20 years 6
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? —	
13a. FATHER'S NAME Jacob Becker		13b. MOTHER'S MAIDEN NAME ?	
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 service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Bell Baum 1426 Belt	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 8 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) arteriosclerotic heart disease		10 years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) Thrombophlebitis l. leg 4/20/49		2 months
19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION —		20. AUTOPSY? YES <input 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 31 1948**, to **4.1 1949**, that I last saw the deceased alive on **4.1 1949**, and that death occurred at **6:15 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Helig Linnor, M.D.		23b. ADDRESS Jewish Sanatorium, 3000 E. 12th St., St. Louis, Mo.		23c. DATE SIGNED 4.1.49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-3-1949	24c. NAME OF CEMETERY OR CREMATORY Chester Shel Emuth	24d. LOCATION (City, town, or county) (State) St Louis County	
DATE REC'D BY LOCAL REG. 4-3-49		REGISTRAR'S SIGNATURE Thurmond W. Linnor, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Oxendaniel 5010 Emigh

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
Student Embalmer

Signed _____

Licensed Embalmer No. 3669

P. O. Address 5010 Enright

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.