

FILED JUN 27 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21838  
5085

Registrar's No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>60 yrs.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>University City</b>		95 3 1
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>			d. STREET ADDRESS (If rural, give location) <b>W.R. 7117 Delmar</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b>		b. (Middle) _____	c. (Last) <b>WEISMAN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 10 1949</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Unk.</b>	9. AGE (In years last birthday) <b>ab 70</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during year or even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Morris Horwitz</b>		13b. MOTHER'S MAIDEN NAME <b>Unk</b>		14. NAME OF HUSBAND OR WIFE <b>Sam</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dr. Sol Weisman 4616 Lindell</b>		
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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____				INTERVAL BETWEEN ONSET AND DEATH <b>10 Hours</b> <b>16 years</b>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>0</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>1021</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>H A H X</b>				
22. I hereby certify that I attended the deceased from <b>March 9, 1943</b> to <b>June 10, 1949</b> , that I last saw the deceased alive on <b>June 2, 1949</b> , and that death occurred at <b>1:25 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Arthur E. Steady M.D.</b>			23b. ADDRESS <b>539 N. Grand</b>		23c. DATE SIGNED <b>8/10/49</b>
24a. BURIAL, CREMA TION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6/12/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		24d. LOCATION (City, town, or county) (State) <b>University City Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JUN 14 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Lavater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>4715 McPherson Berger Memorial</b>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE 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.....

*Luigi Audino*

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.