

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24838
Registrar's No. 6025

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clayton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) N.R. 7560 Wydown	

3. NAME OF DECEASED (Type or Print) a. (First) JENNIE (SHEINDEL) b. (Middle) GREENBERG c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) July 7, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Abt. 80 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) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia	12. CITIZEN OF WHAT COUNTRY? b

13a. FATHER'S NAME Peter Schneider	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Abraham Greenberg
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Morris Greenberg-7560 Wydown
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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		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs many years 2 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio-sclerotic heart disease color DUE TO (c) carcinoma splenic flexure		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1st stage tuberculosis.			

19a. DATE OF OPERATION 7-1-49	19b. MAJOR FINDINGS OF OPERATION carcinoma splenic flexure colon	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) m	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) Hlo (STATE) Mo
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? 153 X

22. I hereby certify that I attended the deceased from July 19 47, to July 7, 19 49, that I last saw the deceased alive on July 7, 19 49, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE Joseph Magidson (Degree or title) M.D.	23b. ADDRESS 520 W. 1st St.	23c. DATE SIGNED 7/9/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/10/49	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem. St. Louis, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. JUL 10 1949	REGISTRAR'S SIGNATURE J. B. Sasator	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hernandez & Sons - 5216 Delmar
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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Name

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 _____

John Ketter
Licensed Embalmer No. 3880

Signed.....
Student Embalmer

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.