

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28122
7299

318 1003 State File No. Registrar's No.

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
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 St. Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5924 DeGiverville		d. STREET ADDRESS (If rural, give location) 5- 5924 DeGiverville	

3. NAME OF DECEASED (Type or Print)		a. (First) ANNIE		b. (Middle)		c. (Last) HANDELMAN Handelman.		4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1949			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH unk		9. AGE (In years last birthday) ab. 72 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME unk Ritter			13b. MOTHER'S MAIDEN NAME unk.			14. NAME OF HUSBAND OR WIFE Nathan					
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.			17. INFORMANT'S SIGNATURE OR NAME Shirley Handelman			ADDRESS 5924 DeGiverville		

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia						4 days	
		ANTECEDENT CAUSES							
		DUE TO (b) Migraine of left foot						1 wk.	
		DUE TO (c) Chronic obstructive pulmonary secondary to obstruction of common duct						3 yrs.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
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)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		1949			
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? 586 X					
22. I hereby certify that I attended the deceased from _____, 19____, to Aug 20, 1949, that I last saw the deceased alive on Aug 20, 1949, and that death occurred at 7:55 A.M., from the causes and on the date stated above.									
23a. SIGNATURE Mavis Oley M.D.				23b. ADDRESS Jewish Hospital				23c. DATE SIGNED 8/20/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/22/49		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		24d. LOCATION (City, town, or county) (State) University City Mo.			
DATE REC'D BY LOCAL REG. AUG 22 1949		REGISTRAR'S SIGNATURE J. B. Fasater		FURNERAL DIRECTOR'S SIGNATURE Berger Memorial 4715 aMcPherson					

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.

Student
Student Embalmer

Signed

Lewis L Ludwig
4229

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