S. No. 300
v. 10.48

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

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38995

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9975

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis Mo.
c. LENGTH OF STAY (in this place): abt 8 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jewish Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 212 N. Kingshighway

3. NAME OF DECEASED (Type or Print): a. (First) Max b. (Middle) c. (Last) Lippman

4. DATE OF DEATH (Month) 11 (Day) 18 (Year) 1949

5. SEX: male
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: December 18/76
9. AGE (In years last birthday): 72 | 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): Executive
10b. KIND OF BUSINESS OR INDUSTRY: Drug Mfg.
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Herman Lippman
13b. MOTHER'S MAIDEN NAME: Lilienfeld
14. NAME OF HUSBAND OR WIFE: Lillie Stampfer Lippman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 489-01-6559
17. INFORMANT'S SIGNATURE OR NAME | ADDRESS

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — Interval between onset and death: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary insufficiency — 2 days.
DUE TO (c)

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 ☑ NO ☐

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) 94
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from April, 1947, to Nov 18, 1949, that I last saw the deceased alive on Nov 18, 1949, and that death occurred at 10:20 P m., from the causes and on the date stated above.

23a. SIGNATURE: Lewis Littmann (Degree or title) MD
23b. ADDRESS: 8231 Clayton Rd (17)
23c. DATE SIGNED: 11/20/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/20/49
24c. NAME OF CEMETERY OR CREMATORY: Mt. Sinai
24d. LOCATION (City, town, or county) (State): St. Louis County Mo.

DATE REC'D BY LOCAL REG. NOV 20 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 4356 Lindell

(Licensed Embalmer's Statement on Reverse Side)

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 J. Wm Binkley

Licensed Embalmer No. 3657

P. O. Address St Louis Mo

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.