

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42609**

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **11223**

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 2 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) University City					
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital				1. STREET ADDRESS (If rural, give location) H.K. 905 Eastgate Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) SARAH			b. (Middle)		c. (Last) JACOBSON		4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1949		
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) Months Days Hours Min. Abt. 76	
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) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Earl Glass			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Isaac Jacobson			
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. UNKNOWN		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Eda Herman-905 Eastgate Ave.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrhage (right)						2 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						DUE TO (b) Generalized arterio sclerosis	
								DUE TO (c)	
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) 91					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331					
22. I hereby certify that I attended the deceased from Dec 26, 1949 , to Dec 28, 1949 , that I last saw the deceased alive on Dec 24, 1949 , and that death occurred at 4:30 p.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Joseph Magidson M.D.				23b. ADDRESS 5700 W. Gate			23c. DATE SIGNED Dec 29-1949		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/30/49		24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. DEC 29 1949		REGISTRAR'S SIGNATURE J. B. Casater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. R. ... 5216 Delmar				

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.....

John Kettes
Licensed Embalmer No. 3880

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.