

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 2778
Registrar's No. 535

BIRTH NO. #107072		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		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2019
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.			d. STREET ADDRESS (If rural, give location) 6137 Louisiana		
3. NAME OF DECEASED (Type or Print)		a. (First) JACOB	b. (Middle)	c. (Last) MARGOLD	4. DATE OF DEATH (Month) (Day) (Year) January 17, 1950
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 23, 1860	9. AGE (in years last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bohemia	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Matthew Margold		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Schaffner 6137 La		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis 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
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 332X		
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?		
22. I hereby certify that I attended the deceased from 1/6/50, 19, to 1/17/50, 19, that I last saw the deceased alive on 1/17/50, 19, and that death occurred at 9:10 a.m., from the causes and on the date stated above.					
23a. SIGNATURE E. J. Jansen M.D.		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 1/17/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) n	24b. DATE Jan 20, 1950	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Paul	24d. LOCATION (City, town, or county) (State) City		
DATE REC'D BY LOCAL REG. JAN 18 1950		REGISTRAR'S SIGNATURE J. Hooper		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Matthew J. Jansen 6322 Grand	

(Licensed Embalmer's Statement on Reverse Side)

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.....

working under my personal supervision.

Signed *David Lee Fessan*.....
Student Embalmer No.

Signed.....
Student Embalmer

Licensed Embalmer No. *4242*.....

P. O. Address *6322 So Grand Blvd*.....

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.