

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

6732

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1545</b>			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>5568 Pershing Ave.</b>					
3. NAME OF DECEASED (Type or Print) <b>JOSEPH</b>			a. (First)			b. (Middle)			
			c. (Last) <b>SHARF</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>2-14-1950</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Unknown</b>			
						9. AGE (In years last birthday) <b>Abt. 66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ravenn Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>6</b>			
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Minnie Sharf</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Ym. no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. J. Sharf-5568 Pershing Ave.</b>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>acute pulmonary edema</b> ANTECEDENT CAUSES DUE TO (b) <b>Coronary occlusion</b> DUE TO (c) <b>Coronary arteriosclerosis</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>4 hours</b> <b>years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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) <b>4201</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 <b>2/14, 1950</b> , to <b>2/14, 1950</b> , that I last saw the deceased alive on <b>2/14, 1950</b> , and that death occurred at <b>10:30 p.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Max S. Traublin</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>634 N. Grand</b>		23c. DATE SIGNED <b>2/15/50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>2/16/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
DATE REC'D BY LOCAL REG. <b>FEB 16 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>5216 Delmar</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

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**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.....  
Student Embalmer

Signed.....

*John Ketter*  
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.