

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15024

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4001

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>6 1/2 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		2069
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>2729 N. Union</u>		
3. NAME OF DECEASED a. (First) <u>ALBERT</u>		b. (Middle) _____	c. (Last) <u>SOLOMON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 1 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Stores</u>	11. BIRTHPLACE (State or foreign country) <u>Rumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Henry Solomon</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Fannie Solomon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Theodore Solomon 1414 Temple Ave.</u>		
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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetic coma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diabetes mellitus</u>			10 years		
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 <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) <u>260X</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	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 <u>1946</u> , to <u>Apr 27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Apr 27</u> , 19 <u>50</u> , and that death occurred at <u>9:30</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Barrett L. Tausig M.D.</u>			23b. ADDRESS <u>4500 Olive St.</u>		23c. DATE SIGNED <u>May 2</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/3/1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>		24d. LOCATION (City, town, or county) (State) <u>University City, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 3 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Berger Memorial 4715 McPherson Ave.</u>	

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 *Quirio A. Quirio*
Licensed Embalmer No. 7229

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.