

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31640

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7865**

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) St. Louis	c. LENGTH OF STAY (in this place) 35	c. CITY (If outside corporate limits, write RURAL and give township) University City	4356
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 1251 Mount Olive	

3. NAME OF DECEASED (Type or Print) GERTRUDE	a. (First)	b. (Middle) FISHMAN	c. (Last) FOX	4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1950
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) Abt. 52 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) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	
13a. FATHER'S NAME Joseph Fishman			13b. MOTHER'S MAIDEN NAME Fannie Orenstein	14. NAME OF HUSBAND OR WIFE Sam F. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Harvey Fox - 1251 Mt. Olive		
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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) Chronic Glomerular Nephritis			INTERVAL BETWEEN ONSET AND DEATH 6 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion			13 mo
	DUE TO (c) Diabetes Mellitus			years
	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)		
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? 260X		

22. I hereby certify that I attended the deceased from **8/27**, 19**46**, to **9/15**, 19**50**, that I last saw the deceased alive on **9/15**, 19**50**, and that death occurred at **2:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Jos. M. Orenstein M.D.	23b. ADDRESS 4500 Olive St.	23c. DATE SIGNED 9/16/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/17/50	24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.
		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. SEP 17 1950	REGISTRAR'S SIGNATURE J. B. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ... 5216 ...
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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 Law M. Simon.....

Licensed Embalmer No. 4343.....

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.