

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34945**
8477

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		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 _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 55 YRS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		2 06 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1400 GOODFELLOW				d. STREET ADDRESS (If rural, give location) 1400 GOODFELLOW			
3. NAME OF DECEASED (Type or Print) a. (First) IDA b. (Middle) SCHOENFELD c. (Last) HYMAN			4. DATE OF DEATH (Month) (Day) (Year) 10 / 6 / 1950				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AB. 71		9. AGE (In years last birthday) AB. 71	IF UNDER 1 YEAR Months Days	IF UNDER 2 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 HOUSEWIFE		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME UNKNOWN CUTTER		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE JOSEPH HYMAN			
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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. R. BLEICH 5736 PAGE AVE.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion ANTECEDENT CAUSES DUE TO (b) Generalized arteriosclerosis DUE TO (c) Diabetes mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 6 hrs many years many years	
19a. DATE OF OPERATION Feb 24, 1949	19b. MAJOR FINDINGS OF OPERATION amputation: right mid thigh. gangrene 3rd toe right foot - arteriosclerosis					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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Slip			
22. I hereby certify that I attended the deceased from June 4, 1942 to Oct 6, 1950 , that I last saw the deceased alive on Oct 6, 1950 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE Joseph Magidson M.D.				23b. ADDRESS 520 W. Lot Gate		23c. DATE SIGNED 10-6-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10/8/1950	24c. NAME OF CEMETERY OR CREMATORY CHESED SHEL EMETH		24d. LOCATION (City, town, or county) (State) UNIVERSITY CITY, MO		
DATE REC'D BY LOCAL REG. OCT 8 1950		REGISTRAR'S SIGNATURE J. B. Lester		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS BERGER MEMORIAL 4715 McPHERSON AVE.			

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 *Paul J. Ludwig*
Licensed Embalmer No. 4229

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.