

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35188

State File No. _____

BIRTH NO. _____

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 861

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp		d. STREET ADDRESS (If rural, give location) 1438 E Grand 0	
3. NAME OF DECEASED (Type or Print) a. (First) MORRIS b. (Middle) c. (Last) Oberman		4. DATE OF DEATH (Month) (Day) (Year) OCT. 12, 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 26 1877
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
10b. KIND OF BUSINESS OR INDUSTRY Soap - up		11. BIRTHPLACE (State or foreign country) USSR	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Ben Oberman	
13b. MOTHER'S M maiden name Sophie (unk)		14. NAME OF HUSBAND OR WIFE Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Sam Oberman		ADDRESS 7515 Wayne St C	
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral vascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis 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 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? 331X			
22. I hereby certify that I attended the deceased from 10/5, 1950, to 10/12, 1950, that I last saw the deceased alive on 10/12, 1950, and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Aaron Brinkman M.D.		23b. ADDRESS 216 S Kings Highway	
23c. DATE SIGNED 10/11/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/12/50	
24c. NAME OF CEMETERY OR CREMATORY Woodlawn		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REG. OCT 13 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 4115 Melrose	

(Licensed Embalmer's Statement on Reverse Side)

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 *Quinn A. Anderson*
Licensed Embalmer No. *4529*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.