

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38557

State File No. 9711

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Jacob		8130 6	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES		b. (Middle)		c. (Last) GREENBERG		4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1950	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Unknown	
9. AGE (In years) (Month) (Day) (Year) Abt. 79		10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Salvage		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Rose Greenberg	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. C. Greenberg-St. Jacob, Ill.			
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) Carcinoma of Bladder ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Not Known DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Nothing				INTERVAL BETWEEN ONSET AND DEATH 3 days	
19a. DATE OF OPERATION July 31 '48		19b. MAJOR FINDINGS OF OPERATION Prostatic obstruction				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? 181X			
22. I hereby certify that I attended the deceased from July 18, 1949 , to Nov 15, 1950 , that I last saw the deceased alive on Nov 14, 1950 , and that death occurred at 4 a. m. , from the causes and on the date stated above.							
23a. SIGNATURE C. B. Sanford M.D.				23b. ADDRESS 958 Arcade Bldg. St. Louis, Mo.		23c. DATE SIGNED Nov 15 '50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/16/50		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem. St. Louis, Mo.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. OFF. NOV 18 1950		REGISTRAR'S SIGNATURE J. B. Sabater		25. FUNERAL DIRECTOR'S SIGNATURE Humanitarian Mortuary		ADDRESS 5216 Delmar	

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 *John Keller* _____

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.