

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

003

State File No. 38750

318

9515

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 9515	
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) St. Louis		c. LENGTH OF STAY (In this place) 4 1/2 yrs.		4. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp.				d. STREET ADDRESS (If rural, give location) 2853 Cherokee			
3. NAME OF DECEASED (Type or Print) a. (First) NATHAN b. (Middle) _____ c. (Last) LEWIN			4. DATE OF DEATH (Month) (Day) (Year) Nov. 8, 1950				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED Married	8. DATE OF BIRTH March 15, 1881	9. AGE (In years last birthday) 69	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) Shoe repair		10b. KIND OF BUSINESS OR INDUSTRY retail shpp.		11. BIRTHPLACE (State or foreign country) USSR		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME UNK.		13b. MOTHER'S MAIDEN NAME UNK.		14. NAME OF HUSBAND OR WIFE Rose			
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 Rose Lewin 2853 Cherokee			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMBOLUS LT PO.				1 1/2 HRS	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTROPHY OF PROSTATE BENIGN				5 yrs	
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DIABETES MELLITUS				5 yrs	
19a. DATE OF OPERATION 11/2/50		19b. MAJOR FINDINGS OF OPERATION HYPERTROPHY OF PROSTATE BENIGN				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? 610X			
22. I hereby certify that I attended the deceased from 4-18, 1947 , to 11-8, 1950 , that I last saw the deceased alive on 11-8, 1950 , and that death occurred at 10:55 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>[Signature]</i>				23b. ADDRESS 2838 So. Grand Blvd		23c. DATE SIGNED 11-9-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11/10/50		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		24d. LOCATION (City, town, or county) (State) University City MO.	
DATE REC'D BY LOCAL REG. NOV 9 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson			

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

Quinn D. Quiring

Licensed Embalmer No. 4829

Signed.....
Student Embalmer

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.