

FILED JUN 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21549

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3063</u>		Registrar's No. <u>2423</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		c. LENGTH OF STAY (In this place) <u>Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>		<u>4452</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7260 Forsythe</u>				d. STREET ADDRESS (If rural, give location) <u>7260 Forsythe</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Benjamin</u>		b. (Middle) <u>S.</u>		c. (Last) <u>Levin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 13, 1951</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Unknown</u>		
9. AGE (In years last birthday) <u>Abt. 64</u>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 YEAR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mgr.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>			11. BIRTHPLACE (State or foreign country) <u>Russia</u>		
12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>Abraham Levin</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Samelson</u>		14. NAME OF HUSBAND OR WIFE <u>Mollie R. Levin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. B. Levin - 7260 Forsythe</u>				
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malnutrition with Multiple Bed sores - Bronchopneumonia</u> DUE TO (b) <u>Cerebral thromboses, multiple</u> DUE TO (c) <u>5 yrs</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>1 wk</u> <u>5 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>352X</u>				20. AUTOPSY? YES <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>1945</u> to <u>June 13, 1951</u> , that I last saw the deceased alive on <u>July 13, 1951</u> , and that death occurred at <u>9:45 AM.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Thomas O'Leary M.D.</u>				23b. ADDRESS <u>601 Humboldt Bldg</u>		23c. DATE SIGNED <u>6/15/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6/14/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grav. Sinai Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>6-14-51</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Donke M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>5716 Delmar</u>		ADDRESS		

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 Ketter
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.