

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED NOV 8 1951

State File No. **35674**

318 **1003**

| | | | | | | | | | |
|--|--|--|---|--|--|---|--|----------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. 9672 | | | |
| 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) _____ | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 20 59 | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital | | | | d. STREET ADDRESS (If rural, give location) 5510 Cates Avenue | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) FANNYE | | b. (Middle) S. | | c. (Last) TAXMAN | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 31, 1951 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 9/28/1893 | | | |
| 9. AGE (In years last birthday) 58 | | IF UNDER 1 YEAR 1 Months 3 Days | | IF UNDER 1 HR. 3 Hours _____ Mins. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) Belleville, Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Samuel Tobias | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Abe B. Taxman | | | |
| 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 Abe B. Taxman-5510 Cates Avenue | | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MItral stenosis | | | | ANTECEDENT CAUSES | | | | 30 yrs | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (b) Rheumatic heart disease | | | | 30 years | |
| | | | | DUE TO (c) _____ | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | | | Hypertensive heart disease | | | | years. | |
| 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 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) _____ m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? H/O X | | | | | |
| 22. I hereby certify that I attended the deceased from 1-15 , 19 44 to 10-31 , 19 51 , that I last saw the deceased alive on 10-31 , 19 51 , and that death occurred at 6:15 p.m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) M. Norman Orzel M.D. | | | | 23b. ADDRESS 508 North Grand Ave. | | 23c. DATE SIGNED 11-1-51 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 11/2/51 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. | | | |
| DATE PREP'D BY LOCAL REGISTRAR'S SIGNATURE NOV 1 1951 J. Carl Smith, M.D., R.P. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. H. ... 5216 ... | | | | | | | |

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

Edouard Duboulet

Licensed Embalmer No.

3691

P. O. Address

Richmond Heights, Va.

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

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