

STANDARD CERTIFICATE OF DEATH

18518

State File No.

MAY 19 1952

318

1003

4020

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 **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) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION **Jewish Hospital** e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis** **2069**

d. STREET ADDRESS (If rural, give location) **2815a Goodfellow**

3. NAME OF DECEASED a. (First) **WILLIAM** b. (Middle) _____ c. (Last) **SCHREIBER** 4. DATE OF DEATH (Month) (Day) (Year) **Apr. 28, 1952**

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 last birthday) **Abt. 51** IF UNDER 1 YEAR Months _____ IF UNDER 24 HRS. Days _____ Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Pharmacist** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **Russia** **6** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Unknown** 13b. MOTHER'S MAIDEN NAME **Unknown** 14. NAME OF HUSBAND OR WIFE **Rose Schreiber**

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. **493-20-8373** 17. INFORMANT'S SIGNATURE OR NAME **Mrs. William Schreiber-2815a Goodfellow** ADDRESS _____

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Chronic glomerulonephritis**
ANTECEDENT CAUSES _____
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____
INTERVAL BETWEEN ONSET AND DEATH **3 years**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **592X**

22. I hereby certify that I attended the deceased from **Jan 18 1949**, to **4/28**, 19**52**, that I last saw the deceased alive on **4/18**, 19**52** and that death occurred at **11:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE **Alfred Goldman MD** (Degree or title) 23b. ADDRESS **634 N. Grand** 23c. DATE SIGNED **4/29/52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **4/30/52** 24c. NAME OF CEMETERY OR CREMATORY **Chesed Shel Emeth Cem.** 24d. LOCATION (City, town, or county) (State) **St. Louis County, Mo.**

DATE REC'D BY LOCAL REG. **APR 29 1952** REGISTRAR'S SIGNATURE **J. Charles Smith MD** FUNERAL DIRECTOR'S SIGNATURE **Herward H. DeLoach** ADDRESS _____

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 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.