

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 3- 1952

State File No. 29615

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7763</b>	
1. PLACE OF DEATH a. COUNTY <b>5</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>2129</b>			
b. CITY OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>7 mo.</b>		c. CITY OR TOWN <b>St. Louis</b>		0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Masonic Home Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>5351 Delmar Blvd.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Philip</b>			b. (Middle)			c. (Last) <b>Isaacson</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 14, 1952</b>							
5. SEX <b>Male 0</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 9, 1866</b>	
9. AGE (In years last birthday) <b>86</b>		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) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>stock handler</b>			11. BIRTHPLACE (State or foreign country) <b>San Francisco, California</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Benjamin Isaacson</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Jeanette Pasternek, deceased</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-09-0068</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Masonic Home of Missouri, 5351 Delmar</b>			
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						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Myocarditis</b>						<b>5 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>DUE TO (b) Hypertension</b>						<b>6 months</b>	
DUE TO (c)							
II. OTHER SIGNIFICANT CONDITIONS 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 type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>No</b>		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? <b>4424X</b>			
22. I hereby certify that I attended the deceased from <b>March 20, 1952</b> , to <b>Aug. 14, 1952</b> , that I last saw the deceased alive on <b>Aug. 14, 1952</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Philip Isaacson M.D.</b>				23b. ADDRESS <b>508 N. Grand Boulevard</b>		23c. DATE SIGNED <b>8/14/52.</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8/17/52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Amoona Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>AUG 15 1952</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Harold Pasternek</b> ADDRESS			

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

---

---

**STATEMENT BY LICENSED EMBALMER**

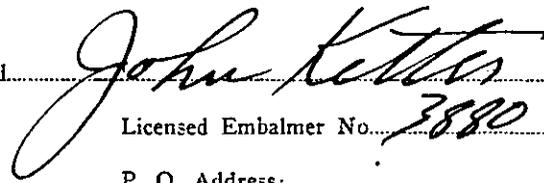
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....



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.