

No. 300
10.48

NOV 12 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36545

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9408**

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. CITY (If outside corporate limits, write RURAL and give township) ST. Louis	
c. LENGTH OF STAY (In this place) 20 yrs		d. STREET ADDRESS (If rural, give location) 5793 Kingsbury	
d. FULL NAME OF HOSPITAL OR INSTITUTION 634 N. Grand			

3. NAME OF DECEASED (Type or Print) a. (First) JACOB b. (Middle) c. (Last) KASKOWITZ			4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Marr.	8. DATE OF BIRTH Nov. 6, 1931	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Albert Kaskowitz.	13b. MOTHER'S MAIDEN NAME Leah Shron	14. NAME OF HUSBAND OR WIFE
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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. Unk	17. INFORMANT'S SIGNATURE OR NAME ADDRESS David Kaskowitz 4416 Westminster
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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) Tn of Skull; Multiple fractures of Body; suffered when		
	ANTECEDENT CAUSES (b) jumped from 6th floor window of the Missouri Theater Bldg. on Oct 11 1952 at about 12:15 pm		
II. OTHER SIGNIFICANT CONDITIONS (c) Suicide, while suffering from temp arary mental aberration		DUE TO (c) Bldg. on Oct 11 1952 at	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Aberration	19. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bldg.	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 11 - 5:12 pm	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E-978X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **2:15 p** m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	23b. ADDRESS 1500 Clark	23c. DATE SIGNED 1-13-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/13/52	24c. NAME OF CEMETERY OR CREMATORY Chevre Kadisha	24d. LOCATION (City, town, or county) (State) University City Mo.
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DATE REC'D BY LOCAL REG. OCT 14 1952	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 Mc herson
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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 *James G. Judwig*
Licensed Embalmer No. 4229

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.