

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

State File No. **26768**
Registrar's No. **6648**

FILED AUG 12 1953

318 PRIMARY REG. DIST. NO. **1003**

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6648	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY _____				a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 WK.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City			
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.				d. STREET ADDRESS (If rural, give location) 7049 Arcadia 4356			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) MORRIS			b. (Middle) _____			c. (Last) PEARLSTEIN	
(Type or Print)			Month July Day 4 Year 1953				
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Male <input checked="" type="checkbox"/>		White		Married		Dec. 25, 1889	
9. AGE (In years less birthday) 63		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY whsale ice cream		11. BIRTHPLACE (City and State or Foreign Country) Hungary	
						12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
Sam Pearlstein			Leah Moscovitz			Mollie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT'S SIGNATURE OR NAME Mrs. M. Pearlstein			
		(If yes, give war or dates of service)		ADDRESS 7049 Arcadia			
MEDICAL CERTIFICATION							
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF BRONCHUS							
INTERVAL BETWEEN ONSET AND DEATH 20 Mos							
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.							
ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
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.							
19a. DATE OF OPERATION Oct 1951		19b. MAJOR FINDINGS OF OPERATION CARCINOMA RT BRONCHUS				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" 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) 16.3 X		(COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 5/25, 1953 , to 7/4, 1953 , that I last saw the deceased alive on 7/4, 1953 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE <i>Harry Cohen</i>				(Degree or title) MD		23b. ADDRESS 624 N. GRAND	
						23c. DATE SIGNED 7/4/53	
24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE 7/6/53		24c. NAME OF CEMETERY OR CREMATORY Chebra kadisha		24d. LOCATION (City, town, or county) (State) University City Mo.	
DATE REC'D BY LOCAL REG. JUL 6 1953		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial ADDRESS 4715 McPherson			

WRITE PLAINLY—USING UNFAADING 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. Quiring

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.