

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29993

State File No. ....

FILED AUG 31 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 7300

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7300			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> (Division) _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) 4 WKS.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Robertson Township # 070</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>Jewish Sabatorium</b>					
3. NAME OF DECEASED (Type or Print) <b>ROSE</b>			a. (First)		b. (Middle)		c. (Last) <b>GORDON</b>		
4. DATE OF DEATH <b>July 26, 1953</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>Nov. 15, 1907</b>	
9. AGE (In years last birthday) <b>45</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 14 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo 0</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13a. FATHER'S NAME <b>Hyman Gordon</b>			13b. MOTHER'S MAIDEN NAME <b>Bella Capman</b>			14. NAME OF HUSBAND OR WIFE <b>Mrs. Mollie Lubin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mollie Lubin</b>				ADDRESS <b>1501 Annadale U. City</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hepato Renal syndrome</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>post surgical</b> DUE TO (c) <b>Cholecystitis, &amp; cholelithiasis;</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Residual Polio - Residual</b>						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION <b>23 July 53</b>		19b. MAJOR FINDINGS OF OPERATION <b>Chronic cholecystitis, cholelithiasis; + stone</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street/office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21f. HOW DID INJURY OCCUR? <b>584 X</b>			
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"/>							
22. I hereby certify that I attended the deceased from <b>1 July, 1953</b> , to <b>26 July, 1953</b> , that I last saw the deceased alive on <b>26 July, 1953</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Stanley Gordon M.D.</b> (Degree or title)				23b. ADDRESS <b>Jewish Hospital &amp; Phil's</b>			23c. DATE SIGNED _____		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>7/29/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emet</b>		24d. LOCATION (City, town, or county) (State) <b>University City Mo.</b>			
DATE REC'D BY LOCAL REG. <b>JUL 28 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Berger Memorial</b>		ADDRESS <b>4715 McPherson</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Quinn J. Quindley*

Licensed Embalmer No..... *4229*

P. O. Address.....

Signed.....  
Student Embalmer

**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.