No. 300
10.48

FILED AUG 20 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30119

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7301

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 1 1/2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: Jewish Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1390 Goodfellow

3. NAME OF DECEASED (Type or Print)
a. (First): HYMAN
b. (Middle):
c. (Last): Kaplan

4. DATE OF DEATH (Month) (Day) (Year): July 27 1953

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr. 15, 1887
9. AGE (In years last birthday): 66 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cap maker
10b. KIND OF BUSINESS OR INDUSTRY: Manf.
11. BIRTHPLACE (State or foreign country): USSR
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Sholem Kaplan
13b. MOTHER'S MAIDEN NAME: Dora (unk)
14. NAME OF HUSBAND OR WIFE: Beckie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Mrs B. Kaplan 1390 Goodfellow

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA & CORONARY THROMBOSIS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HYPERTENSION & ARTERIOSCLEROSIS
DUE TO (c) DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 20 July 53
19b. MAJOR FINDINGS OF OPERATION: Gangrene of foot - amputation
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) m.: —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 260X

22. *I hereby certify that I attended the deceased from* 18 July, 1953, *to* 27 July, 1953 *that I last saw the deceased alive on* 27 July, 1953 *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Stanley Gordon (Degree or title) M.D.
23b. ADDRESS: Jewish Hospital
23c. DATE SIGNED: 27 July 53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 7/28/53
24c. NAME OF CEMETERY OR CREMATORY: Chesed Shel Emeth
24d. LOCATION (City, town, or county) (State): University City Mo.

DATE REC'D BY LOCAL REG.: JUL 28 1953
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Berger Memorial 4715 McPherson
(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.....

Student Embalmer

Signed.....

Licensed Embalmer No.....

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.