

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40377

FILED DEC 4 - 1953

State File No. ....  
Registrar's No. **11066**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>2117</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2710 S. Grand</b>		d. STREET ADDRESS (If rural, give location) <b>2710 S. Grand</b>	

3. NAME OF DECEASED (Type or Print) <b>AARON</b>			a. (First)	b. (Middle)	c. (Last) <b>DOLIN</b>	4. DATE OF DEATH Nov. 20, 1953		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 22, 1878</b>	9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>27</b>	IF UNDER 24 HRS. Hours <b>11</b>	IF UNDER 24 HRS. Mins. <b>27</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
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13a. FATHER'S NAME <b>Abraham Dolin</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Bella Dolin</b>	
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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) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. A. Dolin-2710 S. Grand</b>		ADDRESS	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
		ANTECEDENT CAUSES Morbid 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. <b>Diabetes Mellitus</b>				<b>8 yrs</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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>4200</b>	
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22. I hereby certify that I attended the deceased from **Nov 19 52** to **20 Nov, 1953**, that I last saw the deceased alive on **20 Nov, 1953** and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Richard H. Jones MD</b>		23b. ADDRESS <b>3720 Washington</b>		23c. DATE SIGNED <b>21 Nov 53</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>11/21/53</b>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
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DATE REC'D BY LOCAL REG. <b>NOV 23 1953</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman Rindskopf, Inc., 5212 Delmar Bl.</b>		ADDRESS	
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(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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John Ketter*  
Licensed Embalmer No. 3880

P. O. Address.....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.