

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

6826

BIRTH NO. FILED MAR 5 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1188

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY St. Louis |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN St. Louis |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN Ladue 7437                                  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Bernard Nursing Home                                 |  | d. STREET ADDRESS (If rural, give location)<br>29 Oakleigh Lane  |  |

|   |  |                        |  |  |  |   |  |  |  |                                  |  |
|---|--|------------------------|--|--|--|---|--|--|--|----------------------------------|--|
| 3. NAME OF DECEASED<br>(Type or Print)  |  | a. (First) SOLOMON     |  | b. (Middle)  |  | c. (Last) SLAVIN  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year) |  | Feb. 6, 1954                     |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed |  | 8. DATE OF BIRTH Unknown                                  |  | 9. AGE (In years last birthday)          |  | Abt. 92                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired cabinet maker |  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY                              |  | 11. BIRTHPLACE (City and State or Foreign Country) Russia |  |  |  | 12. CITIZEN OF WHAT COUNTRY? USA |  |

|   |  |                                   |  |   |  |
|---|--|-----------------------------------|--|---|--|
| 13a. FATHER'S NAME Unknown  |  | 13b. MOTHER'S MAIDEN NAME Unknown |  | 14. NAME OF HUSBAND OR WIFE Deborah S. Slavin                             |  |
| 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. no        |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Ben Slavin-29 Oakleigh Lane |  |

|   |  |                          |  |  |  |                                  |  |
|---|--|--------------------------|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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) Carcinoma of left mandible   |  | ANTECEDENT CAUSES        |  |  |  | 1 year                           |  |
| 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  |  | General arteriosclerosis |  |  |  |                                  |  |
| Conditions contributing to the death but not related to the disease or condition causing death.   |  |                          |  |  |  |                                  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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) (COUNTY) (STATE)                          |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR 196x   |  |

22. I hereby certify that I attended the deceased from Jan 19, 1954 to 2/6, 1954, that I last saw the deceased alive on 2/5, 1954, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

|   |  |                           |  |   |  |
|---|--|---------------------------|--|---|--|
| 22a. SIGNATURE (Degree or title) <i>Joseph Johnson M.D.</i> |  | 22b. ADDRESS 634 N. Grand |  | 22c. DATE SIGNED 2/6/54   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Reburial          |  | 24b. DATE 2/7/54          |  | 24c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery               |  |
|   |  |                           |  | 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |  |

|                                     |  |  |  |   |  |
|-------------------------------------|--|--|--|---|--|
| DATE REC'D BY LOCAL REG. FEB 8 1954 |  | REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sherman Rindskopf, Inc., 5216 Delmar |  |
|-------------------------------------|--|--|--|---|--|

(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 with the above constitutes grounds for revocation of license.)

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