

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

13197

3046

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Kirkwood</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes</u>				e. STREET ADDRESS (If rural, give location) <u>229 E. Argonne Avenue</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JULIUS</u>		b. (Middle) <u>L.</u>		c. (Last) <u>BLOCK</u>	
4. DATE OF DEATH		(Month) <u>Apr.</u>		(Day) <u>3,</u>		(Year) <u>1954</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 28, 1899</u>	
9. AGE (In years last birthday) <u>54</u>		10. IF UNDER 1 YEAR Days <u>3</u>		11. IF UNDER 1 HRs. Hours <u>6</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>	
13a. FATHER'S NAME <u>Samuel Block</u>		13b. MOTHER'S MAIDEN NAME <u>Lena Blumenthal</u>		14. NAME OF HUSBAND OR WIFE <u>Sadie Block</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. J.L. Block-229 E. Argonne Ave.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Tongue with metastases to Cervical Nodes</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>radiation to Cervical Nodes</u> DUE TO (c) <u>Coronary Disease</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>18 mths</u> <u>3 yrs</u>	
19a. DATE OF OPERATION <u>10/53</u>		19b. MAJOR FINDINGS OF OPERATION <u>as above</u>				20. AUTOPSY? 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) <u>141X</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>6</u> , 19 <u>53</u> , to <u>4/3</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>2/4/3</u> , 19 <u>54</u> , and that death occurred at <u>11:00</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Charles Smith MD</u> (Degree or Title)				23b. ADDRESS <u>3711 Worthington</u>		23c. DATE SIGNED <u>4/1/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4/5/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>B'nai Amoona Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>APR 5 1954</u>		REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman Rindskopf, Inc., 5216 Delmar</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....  
Signature of Student Embalmer

Signed.....  
*John Ketter*  
Licensed Embalmer No. 388

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.