

FILED JUL 1 - 1954

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21178  
4917

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location)	
ST. LOUIS 0		MISSOURI ST. LOUIS 49 RICHMOND HIGHTS 4993	
DEACONESS HOSPITAL		1125 MOORLANDS DR. 1	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First)	b. (Middle)	c. (Last)	JUNE 1, 1954		
INA	H.	RUBIN			
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR
FEMALE /	WHITE	MARRIED /	MAY 11, 1904	50	XX 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)	
At home				NEBO ILLINOIS /	
12. CITIZEN OF WHAT COUNTRY?			U.S.A.		

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
ALFRED HAMILTON	LOLA HAYNES	BEN RUBIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Unknown	UNKNOWN	BEN RUBIN 1125 MOORLANDS DR.

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		INTERVAL BETWEEN ONSET AND DEATH several years many yrs 4 wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	II. OTHER SIGNIFICANT CONDITIONS		
	Congestion heart failure MORPHETIC heart disease DUE TO (b) DUE TO (c) anticoagulants		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 416X

22. I hereby certify that I attended the deceased from several years, to June 1, 1954, that I last saw the deceased alive on 6-1, 1954, and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Newt... M.D.	St. Louis, Mo.	6-2-54

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL	6/3/54	Mt. Olive Cemetery	ST. LOUIS CO. MISSOURI
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
JUN 3 1954	J. Earl Smith, M.D.	HERMAN RINDSKOPF INC. 5216 DELMAR	

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.....  
Signature of Student Embalmer

Signed, *Peter B. Dubrow*

Licensed Embalmer No. *369*

P. O. Address *St. Louis*

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.