

FILED OCT 26 1954

STANDARD CERTIFICATE OF DEATH

State File No. 35720
Registrar's No. 8548

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8548			
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 St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis					
c. LENGTH OF STAY (In this place) 1 day				d. STREET ADDRESS (If rural, give location) 23 1914a S. Broadway					
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.				4. DATE OF DEATH (Month) (Day) (Year) SEPT. 16, 1954					
3. NAME OF DECEASED (Type or Print)		a. (First) ABRAHAM		b. (Middle) MILLER		c. (Last)			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.		8. DATE OF BIRTH Aug. 20, 1878			
9. AGE (In years last birthday) 76		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retail Dry Gds.		11. BIRTHPLACE (City and State or Foreign Country) USSR			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Miller		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Celia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499-34-7002		17. INFORMANT'S SIGNATURE OR NAME Mrs. Miller		ADDRESS 1914a S. B'dway			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) coronary thrombosis DUE TO (c) Arteriosclerosis / Ht disease				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				19b. MAJOR FINDINGS OF OPERATION	
19c. 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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200					
22. I hereby certify that I attended the deceased from Jan 16, 1952, to Feb 16, 1954, that I last saw the deceased alive on Sep 16, 1954, and that death occurred at 9:30 p.m., from the causes and on the date stated above.									
23a. SIGNATURE Michael M. Karl, M.D.				23b. ADDRESS Jewish Hospital		23c. DATE SIGNED 9-17-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		24b. DATE 9/20/54		24c. NAME OF CEMETERY OR CREMATORY B'nai Amoona		24d. LOCATION (City, town, or county) (State) University City			
DATE REC'D BY LOCAL REG. SEP 18 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson					

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

Sawyer, J. De

Licensed Embalmer No. _____

3188

P. O. Address _____

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

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