

FILED NOV 22 1954

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

State File No. **38767**  
Registrar's No. **9698**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 wks.</b>	c. CITY OR TOWN <b>University City</b>	d. Residence within limits of city or incorporated town? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>			STREET ADDRESS (If rural, give location) <b>723 Syracuse</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>ABRAM</b>		b. (Middle) <b>A.</b>	c. (Last) <b>GOLBART</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 24, 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Marr.</b>	8. DATE OF BIRTH <b>Aug. 9, 1884</b>	9. AGE (in years last birthday) <b>70</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>USSR</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Isaac Golbart</b>		13b. MOTHER'S MAIDEN NAME <b>Malka</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie</b>	
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>Unk.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Bessie Golbart</b> ADDRESS <b>723 Syracuse</b>		
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.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of bile duct</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.  INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>					
19a. DATE OF OPERATION <b>9/23/54</b>	19b. MAJOR FINDINGS OF OPERATION <b>See above</b>		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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>155X</b>			
22. I hereby certify that I attended the deceased from <b>9/20</b> , 19 <b>54</b> , to <b>10/24</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>10/23</b> , 19 <b>54</b> , and that death occurred at <b>6:57A. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>J. Earl Smith M.D.</b> (Degree or title)			23b. ADDRESS <b>500 Olive</b>		23c. DATE SIGNED <b>10/24/54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem.</b>	24b. DATE <b>10/25/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>	24d. LOCATION (City, town, or county) (State) <b>University City Mo.</b>		
DATE REC'D BY LOCAL REG. <b>OCT 25 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Berger Memorial 4715 Mc herson</b>			

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

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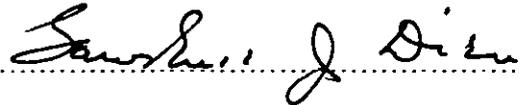
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STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No.....

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.