

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38840**
Registrar's No. **9518**

FILED NOV 22 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN University	
c. LENGTH OF STAY (in this place) 3 days		d. Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		e. STREET ADDRESS (If rural, give location) 735 Leland Ave.	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Hyman	b. (Middle)	c. (Last) Hiken	(Month) (Day) (Year) Oct 19 54
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 10, 1886
9. AGE (In years last birthday) 68		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor	10b. KIND OF BUSINESS OR INDUSTRY Retail Shop
11. BIRTHPLACE (City and State or Foreign Country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Unknown Hiken	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lena Hiken
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lena Hiken ADDRESS 735 Leland Avenue

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		DUE TO (b) Hypertension		2 days
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Chl. Nephritis		5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 592X
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22. I hereby certify that I attended the deceased from **10/17, 1954**, to **10/19, 1954**, that I last saw the deceased alive on **10/19, 1954**, and that death occurred at **5:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Louis Cohen M.D.	23b. ADDRESS 4500 Olive St. St. Louis, Mo.	23c. DATE SIGNED 10/20/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-21-54	24c. NAME OF CEMETERY OR CREMATORY Chevra Kedisha
24d. LOCATION (City, town, or county) (State) University City, Mo.		

DATE REC'D BY LOCAL REG. OCT-20 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE BERGER MEMORIAL ADDRESS 415 McPherson
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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 .....
Licensed Embalmer No. 4289

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.