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10.48

FILED DEC 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42577  
State File No. 11017  
Registrar's No.

318 1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis				c. LENGTH OF STAY (in this place) 2 days		c. CITY OR TOWN St. Louis		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 JEWISH HOSPITAL				STREET ADDRESS (If rural, give location) 6 5637 Easton		20690			
3. NAME OF DECEASED (Type or Print) a. (First) Isadore			b. (Middle)		c. (Last) Lopatin		4. DATE OF DEATH (Month) (Day) (Year) Dec. 3, 1954		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Marr.		8. DATE OF BIRTH Unk.		9. AGE (In years, last birthday) Months Days Hours Min. ab. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10b. KIND OF BUSINESS OR INDUSTRY Retail Grocer		11. BIRTHPLACE (City and State or Foreign Country) USSR 6			12. CITIZEN OF WHAT COUNTRY USSR	
13a. FATHER'S NAME Abr. Lopatin			13b. MOTHER'S MAIDEN NAME --			14. NAME OF HUSBAND OR WIFE Sarah			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sarah Lopatin 5637 Easton				
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalitis, Pulmonary Bronchitis Bronchopneumonia Cor Pulmonale DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 20 years 10 years 1 week 1 month	
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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR 526X				
22. I hereby certify that I attended the deceased from <u>Plowry, 1952</u> , to <u>12/3, 1954</u> , that I last saw the deceased alive on <u>12/3, 1954</u> , and that death occurred at <u>10A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Carl Fred Lehman M.D.				23b. ADDRESS 634 Koganel St. Louis BARNES HOSPITAL Mo.				23c. DATE SIGNED 12/3/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		24b. DATE 12/3/54		24c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha		24d. LOCATION (City, town, or county) (State) University City Mo.			
DATE REC'D BY LOCAL REG. DEC 3 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson				

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 *Reino G. Gudberg*.....  
Licensed Embalmer No..... 482

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.