

FILED MAY 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16795

State File No. _____
Registrar's No. **3875**

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 death.) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN University City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 wk.		e. STREET ADDRESS (If rural, give location) 7943 Delmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) I KE (AKA ISAAC)	b. (Middle)	c. (Last) LEVINSON	4. DATE OF DEATH (Month) (Day) (Year) APRIL 30 1955
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH Unk.	9. AGE (In years last birthday) ab. 76	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	10b. KIND OF BUSINESS OR INDUSTRY retail mens clo.	11. BIRTHPLACE (City and State or Foreign Country) Poland	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Wm. Levinson	13b. MOTHER'S MAIDEN NAME ---	14. NAME OF HUSBAND OR WIFE Mary
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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. Unk.	17. INFORMANT'S SIGNATURE OR NAME Joe Levinson	ADDRESS 7215 Belson
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thromboses, multiple with eucephalomalacia		INTERVAL BETWEEN ONSET AND DEATH years
	DUPLICATE TO (b) Generalized arteriosclerosis		
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 332X
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22. I hereby certify that I attended the deceased from **June, 1947**, to **Apr. 30, 1955**, that I last saw the deceased alive on **April 30, 1955**, and that death occurred at **7 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Max S. Franklin M.D.	(Degree or title)	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 4/30/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	24b. DATE 5/2/55	24c. NAME OF CEMETERY OR CREMATORY Chevre Kadasha	24d. LOCATION (City, town, or county) (State) University City Mo
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DATE REC'D BY LOCAL REG. MAY 2 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	ADDRESS 4715 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.....
Lawrence J. De... ..

Licensed Embalmer No... 398

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.