

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28330

STATE FILE NUMBER

7035

FILED SEP 7 1956

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Brentwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>			Length of stay in 1b <b>3 hrs</b>	d. STREET ADDRESS (If outside, give location) <b>8912 Cardinal Terr.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>DAISY</b> Middle Last <b>EICHLER</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN. 9, 1895</b>		9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESWOMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHILDRENS WEAR</b>		11. BIRTHPLACE (City and state or country) <b>New York, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Morris Moskowitz</b>				14. MOTHER'S MAIDEN NAME <b>Eva (unknown)</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>340-28-5330</b>		17. INFORMANT Address <b>Herschel Eichler 1319 Mendell U.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Nur 1955</b> to <b>July 27, 1956</b> and last saw her <b>alive</b> on <b>July 27, 1956</b> . Death occurred at <b>12:15</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Bernard Hullbert, MD</b>				22b. ADDRESS <b>462 N. Taylor</b>		22c. DATE SIGNED <b>7/28/56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>7/30/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		23d. LOCATION (City, town, or county) (State) <b>University City Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson</b>				25. DATE RECD. BY LOCAL REG. <b>JUL 30 1956</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, MD</b>	

(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.....  
Signature of Student Embalmer

Signed *Quinn G. Anderson*  
Licensed Embalmer No. 484

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.