

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14957

STATE FILE NUMBER

FILED APR 22 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3201

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.			Length of stay in lb D.O.A. 26	STREET ADDRESS (If outside, give location) 1351 Belt	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle (LEVIN) Last LEVINE			4. DATE OF DEATH Month Day Year April 1, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 18 1878	9. AGE (In years last birthday) ab. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	10b. KIND OF BUSINESS OR INDUSTRY Luggage Manf.	11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gedaliah Levine			14. MOTHER'S MAIDEN NAME Unk.		
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 Address Chas. Levine 5892a Easton		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - Left Hemiplegia DUE TO (b) Arteriosclerosis, Generalized DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hiatus Hernia					INTERVAL BETWEEN ONSET AND DEATH 1 day Yrs.
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.)				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from Jan. 57 to 4/1/57 and last saw her alive on 4/1/57 Death occurred at 6 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Kay Greenbaum M.D.			22b. ADDRESS 4652 Maryland		22c. DATE SIGNED 4/2/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 4/2/57	23c. NAME OF CEMETERY OR CREMATORY Chevre Kadisha		23d. LOCATION (City, town, or county) (State) University City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson		ADDRESS	25. DATE RECD. BY LOCAL REG. APR 3 '57	26. REGISTRAR'S SIGNATURE Carl Smith MO	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service
300 1-56
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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

MEDICAL CERTIFICATION

