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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

FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 19290

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4927

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: 01 JewishOldFolksHome — Length of stay in Hospital: 16 yrs 29

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 1438 E. Grand — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First BERYL Middle Last SHEA
4. DATE OF DEATH: Month May Day 26 Year 1957
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH: ab. 1867
9. AGE (In years last birthday): ab 90 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Retired) Stock Handler
10b. KIND OF BUSINESS OR INDUSTRY: Fed. Paper Co.
11. BIRTHPLACE (City and state or country): USSR
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wolf Shea
14. MOTHER'S MAIDEN NAME: (Unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 491-18-1322A
17. INFORMANT: Ben Shea — Address: 1452 Lyndale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Occlusive Vascular Disease C
Gangrene of right leg.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerosis, Gen.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
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 ☐ NO X 2
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 450.1
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 10/53, to 5/26/57 and last saw ~~hee~~ him alive on 5/26/57
Death occurred at 6:55 p. m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: May Greenbaum (Degree or title) M.D.
22b. ADDRESS: 4652 Maryland
22c. DATE SIGNED: 5/27/57
23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 5/27/57
23c. NAME OF CEMETERY OR CREMATORY: Chesed Shel Emeth
23d. LOCATION (City, town, or county) (State): University City, Mo.
24. FUNERAL DIRECTOR ADDRESS: Berger Memorial 4715 McPherson
25. DATE RECD. BY LOCAL REG.: MAY 27 '57
26. REGISTRAR'S SIGNATURE: Karl Smith MD

(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 em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No...398

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.