

alth.  
elfare  
bublic  
ervice

300  
-56

0  
1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29209  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **6771**

|   |                                  |   |  |   |   |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>University City</b>   |   | Inside Limits<br>Yes <input 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  | 27 STREET ADDRESS <b>6244 Cabanne Ave.</b> (If outside, give location)   |   | Reside on Form<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BECKIE</b> Middle Last <b>BERG</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>19</b> Year <b>1957</b>   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Unk.</b>  | 9. AGE (In years last birthday)<br><b>Abt. 77</b>                                 | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Russia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13. FATHER'S NAME<br><b>Unk.</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unk.</b>  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>Unk.</b>  | 17. INFORMANT<br>Address<br><b>Joe Berg 8145 University Dr,</b>  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic CARCINOMA of Liver</b>   |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                  |   |  |   |   |
| DUE TO (b) <b>CARCINOMA of Sigmoid</b>  |                                  |   |  |   | <b>6 mo</b>   |
| <b>GANGRENE of L. Lower leg</b>   |                                  |   |  |   | <b>1 wk</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?<br>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.)<br><b>153x</b>                                  |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>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>Feb, 57</b> to <b>7-19-57</b> and last saw her alive on <b>7-19-57</b><br>Death occurred at <b>6 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |   |   |
| 22a. SIGNATURE<br><b>P. D. Stahl M.D.</b> (Degree or title)   |                                  |   | 22b. ADDRESS<br><b>462 N. Taylor</b>   |   | 22c. DATE SIGNED<br><b>7-20-57</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   | 23b. DATE<br><b>7/21/57</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Chevre Kadisha Cem.</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Missouri</b> |   |
| 24. FUNERAL DIRECTOR<br><b>Herman Rindskopf Inc. 5216 Delmar</b> ADDRESS  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><b>III 20 57</b>   | 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith, M.D.</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 *John Ketter*.....

Licensed Embalmer No. *38*

P. O. Address *St. Louis*

**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.