

FILED NOV 15 1957

THE DIVISION OF HEALTH OF MISSOURI

37157
STATE FILE NUMBER
10261
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> <u>4336</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>		Length of stay in lb <u>12 days</u>	d. STREET ADDRESS (If outside, give location) <u>27 6401 North Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>BERESE</u> Last <u>BERESE</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1883</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens Garments</u>	11. BIRTHPLACE (City and state or country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		14. NAME OF HUSBAND OR WIFE <u>Ida</u>	
13a. FATHER'S NAME <u>Unknown Berese</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>489-16-8796</u>	17. INFORMANT Address <u>Mrs. Alice Pallo, 8 Sleepy Hollow, 01.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PANCREAS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>± 6 MO.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>157 X</u>			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.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <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. Attended the deceased from <u>6/4/57</u> to <u>10/31/57</u> and last saw him alive on <u>10/30/57</u> Death occurred at <u>12:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>David Feldman MD</u>		22b. ADDRESS <u>539 N. GRAND, ST. LOUIS, MO</u>	22c. DATE SIGNED <u>10/31/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/1/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chevra Kedisha</u>	23d. LOCATION (City, town, or county) (State) <u>University City, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Berger Memorial 4715 McPherson</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 31 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m JB</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

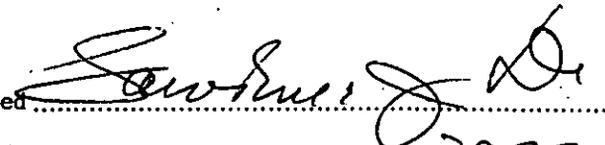
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 3988

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.