Health, & Welfare Public Service

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1-57

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2648

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1157

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 (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 01 2632 Burd — Length of stay in 1b: 55 yrs

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): 2060 2632 Burd — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Bloom
4. DATE OF DEATH: Month 1 Day 30 Year 58
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: (unk)
9. AGE (In years last birthday): ab 87 — 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): Merchant (Retail)
10b. KIND OF BUSINESS OR INDUSTRY: Hardware
11. BIRTHPLACE (City and state or country): Lithuania
12. CITIZEN OF WHAT COUNTRY?: USA
13a. FATHER'S NAME: (unk) Bloom
13b. MOTHER'S MAIDEN NAME: (unknow n)
14. NAME OF HUSBAND OR WIFE: Anna
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.: None
17. INFORMANT: Mrs. G. Goldberg — Address: 2632 Burd Ave

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) Metastatic Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 14 months
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): 181.0

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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. 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 1/9/58 to 1/30/58 and last saw ~~her~~ him alive on 1/25/58
Death occurred at 8 40 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Murray Chinsky M.D.
22b. ADDRESS: 6223 Natural Bridge
22c. DATE SIGNED: 1/30/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 1/31/58
23c. NAME OF CEMETERY OR CREMATORY: Beth Ham Hag Cem.
23d. LOCATION (City, town, or county) (State): Ladue, Mo.

24. FUNERAL DIRECTOR: Berger Memorial — ADDRESS: 4715 McPherson
25. DATE RECD. BY LOCAL REG.: JAN 31 '58
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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. 4229

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.