

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007455

STATE FILE NUMBER

1908

FILED MAR 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		d. STREET ADDRESS (If outside, give location) 1417 Coolidge	
3. NAME OF DECEASED (Type or print) First BEN Middle KOLNICK Last		4. DATE OF DEATH Month Feb. Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Reta il Dry Gds.	11. BIRTHPLACE (City and state or country) Poland
13a. FATHER'S NAME Marcus Kolnick		13b. MOTHER'S MAIDEN NAME Sarah (unk)	14. NAME OF HUSBAND OR WIFE Anna
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. Unk.	17. INFORMANT Address Mrs. Anna Kolnick 1417 Coolidge
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma, colon DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153.8			INTERVAL BETWEEN ONSET AND DEATH 33 mos.
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.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. 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. 29, 1958 to Febr 17, 1958 and last saw ^{her} him alive on Feb. 17, 1958 Death occurred at 11:35 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Josephine Johnson, M.D. (Degree or title)		22b. ADDRESS 3720 Washington	
22c. DATE SIGNED 2-17-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 2/18/58	23c. NAME OF CEMETERY OR CREMATORY B'nai Amoona	23d. LOCATION (City, town, or county) (State) University City, Mo.
24. FUNERAL DIRECTOR ADDRESS Berger memorial 4715 Mc^herson		25. DATE RECD. BY LOCAL REG. FEB 18 '58	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

with, please indicate

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57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.