

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007490  
State File No. 1815

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis, Missouri</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <u>St. Louis State Hospital</u>				STREET ADDRESS (If rural, give location) <b>2570</b> <u>6188 Westminster</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u>		b. (Middle) _____		c. (Last) <u>Levi</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 14, 1958</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Sept. 3, 1900</u>	
9. AGE (In years last birthday) <u>57</u>		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) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Benjamin Levi</u>		13b. MOTHER'S MAIDEN NAME <u>Esther Harris</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Aaron Feiginbaum 6029 Kingsbury</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonitis, left base</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <u>492+</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>1</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 15, 1938</u> , to <u>Feb. 14, 1958</u> , that I last saw the deceased alive on <u>Feb. 14, 1958</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Ramon C. de las Pozas MD</u>				(Degree or title) <u>MD</u>		23b. ADDRESS <u>5100 Arsenal St.</u>	
23c. DATE SIGNED <u>2-15-1958</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-17-58</u>		24b. DATE <u>2-17-58</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>		DATE REC'D BY LOCAL REG. <u>FFR 15 58</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith - MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rindskopf Funeral Home 5216 Delmar</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Ramon C. de las Pozas, M.D.

**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 *Peter B. Dubouille*

Licensed Embalmer No. *3691*

P. O. Address *Providence*

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.