

1th,  
lfare  
lic  
vice

FILED MAR 5 - 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008181  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 355

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <del>St. Louis</del>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maplewood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <del>Maplewood</del> <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>37 Hanley Home</b>		Length of stay in lb <b>5 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>6229 San Bonita</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>BOOKMAN</b> Last <b>BOOKMAN</b>			4. DATE OF DEATH Month <b>Feb</b> Day <b>4</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unk.</b>	9. AGE (In years last birthday) <b>ab. 84</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>USSR</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Morris Gibstine</b>		13b. MOTHER'S MAIDEN NAME <b>Rose (unk)</b>		14. NAME OF HUSBAND OR WIFE <b>John</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Max Bookman 1101 Surrey Hills</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery thrombosis, lft.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Cerebral arterio sclerosis</b>					<b>5 years.</b>
DUE TO (c) <b>Old hemiplegia, right</b>					<b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>332X</b>					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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/>					
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 1939</b> to <b>2/4/58</b> and last saw her <sup>her</sup> alive on <b>2/3/58</b> Death occurred at <b>225 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Alfred Buchman MD</b>			22b. ADDRESS <b>638 No. Penn</b>		22c. DATE SIGNED <b>2/5/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur.</b>		23b. DATE <b>2/6/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chesed Shel Emeth</b>		23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>
24. FUNERAL DIRECTOR <b>Berger memorial 4715 Mc herson</b>			25. DATE RECD. BY LOCAL REG. <b>2/5/58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Danke M.D.</b> <i>sm</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

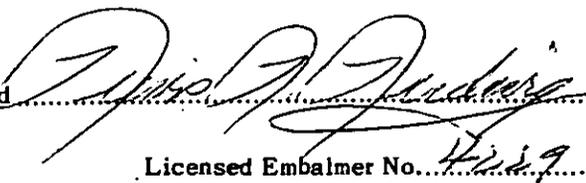
MEDICAL CERTIFICATION

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. 4219 .....

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.