

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016388
STATE FILE NUMBER

FILED MAY 12 1958

1003

Registration District No.

318

Primary Registration District No.

Registrar's No.

4677

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City <i>4/30/58</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 8332 Orchard Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED First Middle Last GERTRUDE RUBIN			4. DATE OF DEATH APRIL 29th, 1958
5. SEX Female	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 March 17, 1893
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	11. BIRTHPLACE (City and state or country) St. Louis Missouri
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME SAMUEL CHERRY		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE JOE RUBIN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNK.		16. SOCIAL SECURITY NO. UNK.	17. INFORMANT Address Mr. Joe Rubin 8332 Orchard Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Renal Failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cholelithiasis & Common Duct Ectasia</i> DUE TO (c) <i>Obstructive Jaundice - Stones in C.D.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertension - Cardio Vascular Renal Disease + Obesity</i>			INTERVAL BETWEEN ONSET AND DEATH <i>24 Hours</i> <i>7-10 days</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>584+</i>		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. I attended the deceased from <i>4/22/58</i> to <i>4/29/58</i> and last saw her alive on <i>4/29/58</i> Death occurred at <i>5:15 pm</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Oliver Goldfarb, M.D.</i>		22b. ADDRESS <i>100 N. Euclid Ave</i>	22c. DATE SIGNED <i>4/30/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/1/58	23c. NAME OF CEMETERY OR CREMATORY B'Nai Amoona Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
24. FUNERAL DIRECTOR ADDRESS Herman Rindskopf Inc. 5216 Delmar		25. DATE RECD. BY LOCAL REG. MAY 1 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> <i>m 876</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 *John Ketter*
Licensed Embalmer No. *3880*
P. O. Address *St. Louis*

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.