

FILED MAY 12 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016700
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1243

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-57

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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		c. CITY OR TOWN Clayton 4434	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION County Hosp.		d. STREET ADDRESS (If outside, give location) 7567 Clayton Rd.	
Length of stay in 1b 5 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First JULIUS Middle H. Last LEIBSON			4. DATE OF DEATH Month May Day 5 Year 1958		
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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 July 13, 1883	9. AGE (In years (birth day)) 74	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Man.	10b. KIND OF BUSINESS OR INDUSTRY Ladies' Wear	11. BIRTHPLACE (City and state or country) Lithuania	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Lieb Leibson	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE Ethel
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 497-09-4652	17. INFORMANT Ben Hoffma n Address 7410 Wellington
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease.		INTERVAL BETWEEN ONSET AND DEATH 11 yr. 15 year.
DUE TO (b) Ren. Arteriosclerosis.		
DUE TO (c) 4201		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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
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21. I attended the deceased from Death occurred at 9:00 AM May 5, 1958 on the date stated above; and to the best of my knowledge, from the causes stated.	and last saw her alive on May 3, 1958
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22a. SIGNATURE (Degree or title) Alex H. Kaplan M.D.	22b. ADDRESS 4652 Maryland Ave.	22c. DATE SIGNED May 6, 1958
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23a. BURIAL, CREMATION, REMOVAL (Specify) Bur.	23b. DATE 5/17/58	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagadol	23d. LOCATION (City, town, or county) (State) Ladue, Mo.
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24. FUNERAL DIRECTOR Berger Memorial	ADDRESS 4 715 McPherson	25. DATE RECD. BY LOCAL REG. 5-6-58	26. REGISTRAR'S SIGNATURE Herbert R. Dombi M.D.
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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
Robert J. De...

Licensed Embalmer No. 3988

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.