

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026936

STATE FILE NUMBER

FILED AUG 7 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2378

1. PLACE OF DEATH a. COUNTY		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 St. Louis		c. CITY OR TOWN University City 4366	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS (If outside, give location) 1315 Coolidge	
3. NAME OF DECEASED (Type or print) First Middle Last SAM (AKA SAMUEL) FINKELSTEIN		4. DATE OF DEATH Month Day Year July 27, 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 Apr. 25, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Men's Wear Store	9. AGE (In years birthday) 72
13a. FATHER'S NAME Jos. Finkelstein		13b. MOTHER'S MAIDEN NAME Jennie (unk)	11. BIRTHPLACE (City and state or country) USSR
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. 500-30-4663	12. CITIZEN OF WHAT COUNTRY? USA
13c. NAME OF HUSBAND OR WIFE Minnie		17. INFORMANT Address Minnie Finkelstein 1315 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) Myocardial infarction DUE TO (b) Coronary artery disease DUE TO (c) 420.1 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
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.		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 Aug 1955 to July 28 1958 and last saw him alive on 7-28-58 Death occurred at 1 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Donald L. Carter MD		22b. ADDRESS 730 Hiramment	
22c. DATE SIGNED 7-28-58		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 7/29/58	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth		23d. LOCATION (City, town, or county) (State) University City, Mo.	
24. FUNERAL DIRECTOR Berger Memorial 4715 11therson		25. DATE RECD. BY LOCAL REG. JUL 28 58	
26. REGISTRAR'S SIGNATURE Earl Smith MD			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Jewis R. Ludwig*
Licensed Embalmer No. 4279.....

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.