Health, & Welfare Public Service

300

1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030484
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8579

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis Missouri — Inside Limits Yes [X] No [ ]

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Jewish Old Folks Home — Length of stay in 1b 56 Years

d. STREET ADDRESS (If outside, give location) 1438 E. Grand — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First BENJAMIN Middle Last HARRIS

4. DATE OF DEATH Month Sept. Day 4, Year 1958

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH June 4, 1884

9. AGE (In years last birthday) 74 — 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) Paper Hanger

10b. KIND OF BUSINESS OR INDUSTRY Decorator

11. BIRTHPLACE (City and state or country) Philadelphia Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Jos. Harris

13b. MOTHER'S MAIDEN NAME (Unk)

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 500-18-9086A

17. INFORMANT Louis Harris Address Ambassador Hotel

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis, Multiple	3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral Arteriosclerosis	Yrs.
DUE TO (c)	Generalized Arteriosclerosis	Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Residual of left Hemiplegia 332X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1954, to Sept. 4, 1958 and last saw her/him alive on 9/2/58
Death occurred at 4:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Roy Guerbaum MD

22b. ADDRESS 4652 Maryland.

22c. DATE SIGNED 9/4/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 9/5/58

23c. NAME OF CEMETERY OR CREMATORY Chevrah Kadisha

23d. LOCATION (City, town, or county) (State) University City Missouri

24. FUNERAL DIRECTOR Berger Memorial ADDRESS 4715 McPherson Ave.

25. DATE RECD. BY LOCAL REG. SEP 5 '58

26. REGISTRAR'S SIGNATURE J. Earl Smith M.D. M.D.B.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. 4229

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.