

Health & Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030526
STATE FILE NUMBER 7623

FILED AUG 28 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 7623

S. 300
 1-1-1
 All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis Mo.</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Jewish Hosp.</i>		Length of stay in lb <i>One week 20 1958</i>	d. STREET ADDRESS (If outside, give location) <i>1438 E. Grand</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Fannie</i> Middle Last <i>Hoffman</i>			4. DATE OF DEATH Month <i>Aug.</i> Day <i>5</i> Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 15, 1888</i>
9. AGE (In years last birthday) <i>70 1/2</i>		10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (City and state or country) <i>U.S.B.R.</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>(unk)</i>	
13b. MOTHER'S MAIDEN NAME <i>(unk)</i>		14. NAME OF HUSBAND OR WIFE <i>Sigmund</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Sigmund Hoffman 1438 E. Grand</i>
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>Myocardial Insufficiency secondary to blood loss following operative procedure at Jewish Hospital on August 4, 1958</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>at Jewish Hospital on August 4, 1958</i> DUE TO (c) <i>4/4/1958</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT <input checked="" 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.) <i>561.4</i>		
20c. TIME OF INJURY Hour a.m. p.m. <i>8 4 58</i>			
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.) <i>12 Hosp</i>	
20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>3:45 a.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Patrick E. Taylor</i> M.D. <input type="checkbox"/>		22b. ADDRESS <i>1300 Olive St.</i>	
22c. DATE SIGNED <i>8/12</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>8/6/58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Chesed Shel Emeth</i>	23d. LOCATION (City, town, or county) (State) <i>University City Missouri</i>
24. FUNERAL DIRECTOR <i>Berger Memorial 4715 McPherson Ave.</i>		25. DATE RECD. BY LOCAL REG. <i>AUG 6 '58</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> <i>W. J. B.</i>

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 *Edward J. Lewis*

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.