

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003505

STATE FILE NUMBER

2 840

FILED FEB 16 1959

Registration District No. _____ Primary Registration District No. _____

Registration No. _____

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-57
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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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City c
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		Length of stay in 1b 1 day	d. STREET ADDRESS (If outside, give location) 749 Heman
3. NAME OF DECEASED (Type or print) WILLIAM SIEGELMAN			4. DATE OF DEATH Month Day Year Jan. 23, 1959
5. SEX Male 0	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 Mar. 25, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Designer		10b. KIND OF BUSINESS OR INDUSTRY Ladies Garm. Mang.	9. AGE (In years & 1/2 rhdays) 76
13a. FATHER'S NAME Unk. Siegelman		13b. MOTHER'S MAIDEN NAME Unk.	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 488-07-2470-3	14. NAME OF HUSBAND OR WIFE Sadie
17. INFORMANT Sadie Siegelman 749 Heman			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 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
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from April 1, 1951 to June 23, 1959 and last saw him alive on Jan. 23, 1959. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Julius Elson M.D.		22b. ADDRESS 607 N. Grand St. St. Louis, Mo	
22c. DATE SIGNED June 24, 1959		22d. ADDRESS (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.		23b. DATE 1/25/59	
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 McPherson		25. DATE RECD. BY LOCAL REG. 1-24-1959	
26. REGISTRAR'S SIGNATURE Carl Smith MO		26. REGISTRAR'S SIGNATURE mrb.	

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 

Licensed Embalmer No. 4265

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.