

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003583

STATE FILE NUMBER 164

FILED JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

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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		
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 St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hosp.		Length of stay in lb 53 yrs.	d. STREET ADDRESS (If outside, give location) 2057 5747 Westminister		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROSE TORIN			4. DATE OF DEATH Month Day Year Jan. 6, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ab. 1885		9. AGE (In years at birthday) ab. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life or retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Mordecai Druyan		13b. MOTHER'S MAIDEN NAME Esther		14. NAME OF HUSBAND OR WIFE Louis	
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. None	17. INFORMANT Address Louis Torin 5747 Westminister		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>42014</u>					INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u> <u>6 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Diabetes mellitus Carcinoma of the colon splenic flexure</u>					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.)			
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 <u>8/16/54</u> to <u>1/6/59</u> and last saw her alive on <u>1/6/59</u> Death occurred at <u>10 15/A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Thomas Alley MD.</u>			22b. ADDRESS <u>3720 Washington Ave</u>		22c. DATE SIGNED <u>1/6/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>rem.</u>		23b. DATE <u>1/8/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Hamedrsoh Hagadol</u>		23d. LOCATION (City, town, or county) (State) <u>Ladue, Mo.</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPerson</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 7 '59</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> <u>mqb</u>	

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 Sawyer J. Deane

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.