

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007412  
STATE FILE NUMBER  
2-1343

FILED FEB 24 1959

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

300  
1-57

72  
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hosp.</b>		Length of stay in lb <b>65 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>5739 Westminister</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>SAM (AKA SAMUEL) MANNE</b>			4. DATE OF DEATH Month Day Year <b>Feb. 7, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1892</b>		9. AGE (In years last birthday) <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>City Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Assessors Off.</b>	11. BIRTHPLACE (City and state or country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Henry Manne</b>		13b. MOTHER'S MAIDEN NAME <b>Lottie (unk)</b>		14. NAME OF HUSBAND OR WIFE <b>Ida</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489 073 3226</b>	17. INFORMANT Address <b>Ida Manne 5739 Westminister</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b>		<b>years</b>
DUE TO (c) <b>4 2 2, 1</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>		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 <b>Dec. 29, 1958</b> , to <b>Feb. 7, 1959</b> and last saw him alive on <b>Feb. 6, 1959</b> . Death occurred at <b>3:45 a.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>Aaron Birenbaum M.D.</b>	22b. ADDRESS <b>462 N. Taylor</b>	22c. DATE SIGNED <b>2/7/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>rem.</b>	23b. DATE <b>2/8/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>B'nai Amoona</b>
		23d. LOCATION (City, town, or county) (State) <b>University City, Mo.</b>

24. FUNERAL DIRECTOR ADDRESS <b>Berger Memorial 4715 McPherson</b>	25. DATE RECD. BY LOCAL REG. <b>FEB 7 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>
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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. Deen* .....  
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.