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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007438
STATE FILE NUMBER

FILED FEB 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1209

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Mo.
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — 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) Hamilton Med. Center — Length of stay in lb 53 yrs.	d. STREET ADDRESS (If outside, give location) 6022 Westminister — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First NATHAN Middle Last MENDELSON		4. DATE OF DEATH Month Day Year Feb. 2, 1959	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH Sept. 1, 1891
9. AGE (In years last birthday) 67	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) Buyer	10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (City and state or country) USBR 6	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Simon Mendelson	13b. MOTHER'S MAIDEN NAME Rachel Shapiro	14. NAME OF HUSBAND OR WIFE Lillian	
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. 488-03-3319	17. INFORMANT Address Lillian Mendelson 6022 Westminister	

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 vascular accidents	4 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Hypertensive Heart Disease	yrs.
DUE TO (c)	Arteriosclerosis Generalized 4200	yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 1

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 5/11/58, to 2/2/59 and last saw her/him alive on 2/2/59
Death occurred at 5 50 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joe M. Orenstein, M.D.	22b. ADDRESS 4500 Olive St	22c. DATE SIGNED 2/3/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem.	23b. DATE 2/4/59	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol
23d. LOCATION (City, town, or county) (State) Ladue, Mo.		
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson	25. DATE RECD. BY LOCAL REG. FEB 3 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. 229

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.