

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015395

STATE FILE NUMBER

2 3437

FILED MAY 8 1959

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

Registrar No. \_\_\_\_\_

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

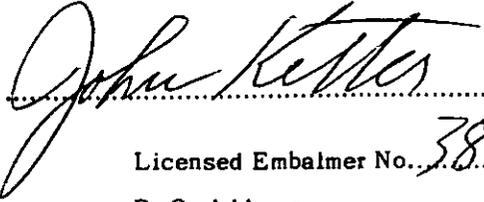
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4 Hamilton Nursing Home		Length of stay in 1b	d. STREET ADDRESS 7712 Wellington
3. NAME OF DECEASED (Type or print) First Middle Last ROSA MARKOVITZ			4. DATE OF DEATH Month Day Year Apr. 6, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days Hours Min. Abt. 80
11. BIRTHPLACE (City and state or country) Romania		12. CITIZEN OF WHAT COUNTRY? 6 U.S.A.	
13a. FATHER'S NAME Louis Leibowitz		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Max Markovitz
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. Unk.	17. INFORMANT Address Leo Markovitz-7712 Wellington
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>Arteriosclerotic CV Disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>422.1</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Myxedema, Senility</i>			INTERVAL BETWEEN ONSET AND DEATH <i>9 yrs</i>
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <i>6/4/54</i> to <i>4/6/59</i> and last saw her <i>4/6/59</i> Death occurred at <i>9:45 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <i>4/7/59</i>	
22a. SIGNATURE <i>Mavis O'Leary MD</i>		22b. ADDRESS <i>3720 Washington</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <i>4/8/59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Bhevera Kadisha Cem.</i>
23d. LOCATION (City, town, or county) <i>St. Louis County, Mo.</i>		23e. STATE <i>Mo.</i>	
24. FUNERAL DIRECTOR <i>Herman Rindskopf, Inc. 5216 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>APR 8 '59</i>	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</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  .....  
Licensed Embalmer No. 3880 .....  
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.