

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015829

STATE FILE NUMBER

FILED MAY 1 1959 Registration District No. Primary Registration District No. Registrar No. 2897

300  
1-57  
5  
795

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Mo. b. COUNTY |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>St. Louis                      |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                            | c. CITY OR TOWN<br>St. Louis  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Jewish Hosp. |  | Length of stay in 1b<br>35 yrs.   | d. STREET ADDRESS (If outside, give location)<br>1438 B. Grand                        |
|   |  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>CELIA TEITELBAUM |  |  | 4. DATE OF DEATH<br>Month Day Year<br>Mar. 21, 1959 |  |  |
|--|--|--|---|--|--|

|                  |                           |   |                                   |                                       |                               |                                |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|-------------------------------|--------------------------------|
| 5. SEX<br>Female | 6. COLOR OR RACE<br>White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Mar. 28, 1878 | 9. AGE (In years last birthday)<br>80 | F UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|-------------------------------|--------------------------------|

|  |                                   |   |                                     |
|--|-----------------------------------|---|-------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br>Austria | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
|--|-----------------------------------|---|-------------------------------------|

|                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| 13a. FATHER'S NAME<br>Samuel Katz | 13b. MOTHER'S MAIDEN NAME<br>Frieda (unk) | 14. NAME OF HUSBAND OR WIFE<br>Isaac |
|-----------------------------------|---|--------------------------------------|

|   |                                 |   |
|---|---------------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No | 16. SOCIAL SECURITY NO.<br>None | 17. INFORMANT Address<br>Rabbi S. Teitelbaum 261-16 83rd, N.Y. City |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>DUE TO (b) ASPIRATION<br>DUE TO (c) DIGITALIS INTOXICATION 8789 46 |  | INTERVAL BETWEEN ONSET AND DEATH<br>18 hrs.<br>18 hrs.<br>7 days                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>SMALL BOWEL ILEUS   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|--|
| 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<br>Hour Month, Day, Year<br>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 MAR. 19, 1959 to MAR. 21, 1959 and last saw her alive on MAR. 21, 1959  
Death occurred at 9:45 AM MAR. 21, 1959 m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |  |                                  |
|---|--|----------------------------------|
| 22a. SIGNATURE (Degree or title)<br>Robert Rubin M.D. | 22b. ADDRESS<br>216 S. Kingshighway, St. Louis | 22c. DATE SIGNED<br>Mar 23, 1959 |
|---|--|----------------------------------|

|   |                      |  |   |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Rem. | 23b. DATE<br>3/23/59 | 23c. NAME OF CEMETERY OR CREMATORY<br>Chevra Kadisha | 23d. LOCATION (City, town, or county) (State)<br>University City, Mo. |
|---|----------------------|--|---|

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|--|--|---|
| 24. FUNERAL DIRECTOR<br>Berger Memorial 4715 McPherson | 25. DATE RECD. BY LOCAL REG.<br>MAR 23 '59 | 26. REGISTRAR'S SIGNATURE<br>Earl Smith, M.D. |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Causes of death are most often only symptoms - none are listed. All diseases in Part I must be causally related.

M. G. B

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 *Lawrence J. Davis* .....

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.