

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016095

FILED APR 27 1959

Registration District No. 317 Primary Registration District No. 541 STATE FILE NUMBER 1100 Registrar's No.

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) DOA County Hosp.		d. STREET ADDRESS 7576 Melrose	
3. NAME OF DECEASED HYMAN ZIEGELMAN		4. DATE OF DEATH Apr. 20, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10b. KIND OF BUSINESS OR INDUSTRY Garm. Manf.	11. BIRTHPLACE (City and state or country) USSR
13a. FATHER'S NAME Isadore Ziegelman		13b. MOTHER'S MAIDEN NAME Sarah (unk)	14. NAME OF HUSBAND OR WIFE Elsie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-05-5810	17. INFORMANT Elsie Ziegelman 7576 Melrose
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural Causes Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7954			INTERVAL BETWEEN ONSET AND DEATH
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 WORK <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 _____, to _____ and last saw her alive on _____ Death occurred at 4:41P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John C. Murphy MD Acting Health Commissioner		22b. ADDRESS 801 S. Brentwood Clayton, Mo.	22c. DATE SIGNED 4/23/59
23a. BURIAL, CREMATION, REINTERMENT Burial	23b. DATE 4/22/59	23c. NAME OF CEMETERY OR CREMATORY Chevra Kadisha	23d. LOCATION (City, town, or county) (State) University City, Mo.
24. BURIAL PERMIT NO. 4715 PERSON Berger		25. DATE RECD. BY LOCAL REG. 4-21-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

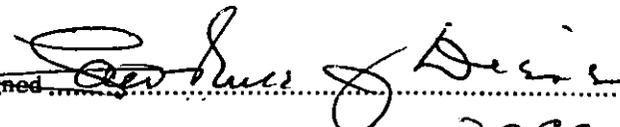
MEDICAL CERTIFICATION

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 

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.