

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022983

STATE FILE NUMBER

FILED JUL 2 1959 Registration District No. Primary Registration District No. 2 5868

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION Folks Home | | Length of stay in lb 6 mos | d. STREET ADDRESS 1438 E. Grand (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last JACOB HERMANSON | | | 4. DATE OF DEATH Month Day Year 6-20-59 | | |
|---|--|--|---|--|--|

| | | | | | | |
|----------------|---------------------------|---|-------------------------------|----------------------------------|--------------------------------|-------------------------------|
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Nov. 1874 | 9. AGE (In years birthday) 84 | 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) Merchant Retired | 10b. KIND OF BUSINESS OR INDUSTRY Used Clothing | 11. BIRTHPLACE (City and state or country) USSR | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|--|-------------------------------------|

| | | |
|-------------------------------------|----------------------------------|------------------------------------|
| 13a. FATHER'S NAME Unk Hermanson | 13b. MOTHER'S MAIDEN NAME Unk | 14. NAME OF HUSBAND OR WIFE Unk |
|-------------------------------------|----------------------------------|------------------------------------|

| | | | |
|---|-------------------------|--------------------------|---------------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or date of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT I. Gers | Address 7430 Stanford U. City, Mo. |
|---|-------------------------|--------------------------|---------------------------------------|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis & Right Hemiparesis</u> DUE TO (b) <u>Arteriosclerosis, Gen.</u> DUE TO (c) <u>332x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) | | 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 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 <u>1/59</u> to <u>6/20/59</u> and last saw her alive on <u>6/19/59</u> Death occurred at <u>8:55 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | |
|--|--|

| | | |
|--|--------------------------------------|------------------------------------|
| 22a. SIGNATURE <u>Roy Greenbaum M.D.</u> (Degree or title) | 22b. ADDRESS <u>4652 Maryland</u> | 22c. DATE SIGNED <u>6/21/59</u> |
|--|--------------------------------------|------------------------------------|

| | | | |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, removal (Specify) | 23b. DATE <u>6-21-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Hamedrosh Hagodol</u> | 23d. LOCATION (City, town, or county) (State) <u>Ladue, Missouri</u> |
|---|-----------------------------|---|---|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>JUN 21 1959</u> | 26. REGISTRAR'S SIGNATURE <u>John Road Smith, M.D.</u> |
|--|--|---|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

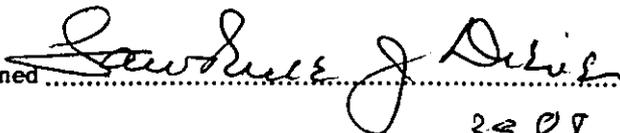
Health, Welfare, Public Service

00
57
7
795
0

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.