

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026843

FILED VS AUG 4 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6839** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 35 yrs	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JE WISH HOSP. OF ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1489 BLACKSTONE
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <input checked="" type="checkbox"/> Middle Last ABE (ABRAHAM) KLEIMAN			4. DATE OF DEATH Month Day Year JULY 21 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 JAN 1875	9. AGE (last birthday) 84	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Scrap metal		10b. KIND OF BUSINESS OR INDUSTRY Metal	11. BIRTHPLACE (City and state or country) RUSSIA	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Hyman Kleiman		13b. MOTHER'S MAIDEN NAME UNK.	14. NAME OF HUSBAND OR WIFE LEONA KLEIMAN		
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. None	17. INFORMANT Address Mrs. A. Kleiman 1489 Blackstone		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK		INTERVAL BETWEEN ONSET AND DEATH 2-3 MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) TOXEMIA	
	DUE TO (c) COMMON BILE DUCT C.B.D. (STONE) OBSTRUCTION 584x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CVA, A.S.H.D., OLD MYOC. INFARCT.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 a.m. p.m. Month, Day, Year		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 **July 27, 1959** to _____ and last saw ^{her}him alive on **7-27-59**
Death occurred at **7:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert S. Mendelsohn, M.D.		22b. ADDRESS Jewish Hospital	22c. DATE SIGNED 7-22-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/23/59	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth	23d. LOCATION (City, town, or county) (State) University City Missouri
24. FUNERAL DIRECTOR ADDRESS Berger Memorial 4715 McPherson Ave.		25. DATE RECD. BY LOCAL REG. JUL 23 '59	26. REGISTRAR'S SIGNATURE Harold Smith, M.D. mrb

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Paul D. Dindary

Licensed Embalmer No. 4889

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.