

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030435

DECEASED AUG 27 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7377** STATE FILE NUMBER

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 TOWN St. Louis		Length of stay in 1b 49 yrs	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hosp		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5800 Arsenal Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) HARRY ABE GREENBERG (First) (aka Herschel Sorokie) (Middle) Sorokie (Last)			4. DATE OF DEATH Month August Day 7 Year 1959	
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5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broom maker		10b. KIND OF BUSINESS OR INDUSTRY Ind. Aid for Blind		11. BIRTHPLACE (City and state or country) USSR		12. CITIZEN OF WHAT COUNTRY US

13a. FATHER'S NAME Joseph Sorokie		13b. MOTHER'S MAIDEN NAME Bessie Hartstraub		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes, give No or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Jos. Tabac 1820 Beverly Glen Blvd Los Angeles 25 Calif	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull at the base with large hemorrhage on the right side.			INTERVAL BETWEEN ONSET AND DEATH
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)			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 AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Slipped up fall to floor at Saint Louis Hosp			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year 8 7 59	Hospital on August 7, 1959.				

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hosp.	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her alive on **8-7-1959**
Death occurred at **11:50 a.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patrick Taylor Carover (Degree or title)		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 8 8 59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8-9-59	23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.	23d. LOCATION (City, town, or county) (State) Univ. City, Mo.	

24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson	25. DATE RECD. BY LOCAL REG. AUG 8 '59	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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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 Frederic J. DeLuca

Licensed Embalmer No. 3988

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.